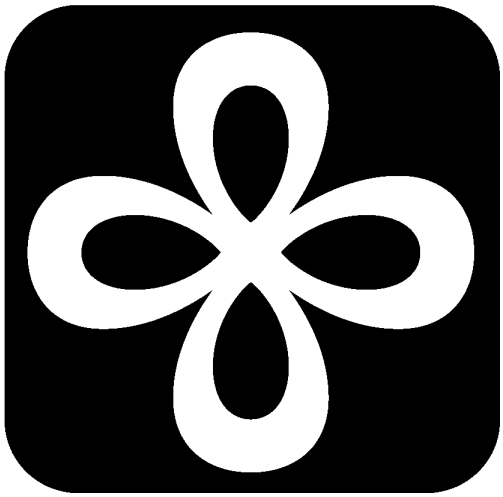
STATE OF IOWA
DEPARTMENT OF HUMAN SERVICES

# MEDICAID



# Provider Manual

## Physician Services

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**APPENDIX**

# I. PHYSICIANS ELIGIBLE TO PARTICIPATE

All physicians (doctors of medicine and osteopathy) licensed to practice in Iowa are eligible to participate in the Medicaid program. Physicians in other states are also eligible to participate, providing they are duly licensed in that state.

# II. COVERAGE OF PHYSICIAN SERVICES

With the cooperation and advice of the State Medical and State Osteopathic Advisory Committees, the Department has established standards governing care for which payment will be made and has formulated general policies and procedures to be followed. Payment will be approved for all reasonable and necessary medical services and supplies, subject to the exclusions and limitations set forth in this chapter.

## A. Services of Auxiliary Personnel

Payment will be approved to the physician for services rendered by auxiliary personnel employed by the physician and working under the physician's direct personal supervision, when such services are performed incident to the physician's professional services.

Auxiliary personnel are nurses, advanced registered nurse practitioners, physician's assistants, psychologists, social workers, audiologists, occupational therapists, and physical therapists. An auxiliary person is considered to be an employee of the physician if the following conditions are met:

- The physician is able to control when, where, and how the work is done. This control need not actually be exercised by the physician.
- The physician sets work standards.
- The physician establishes job descriptions.
- The physician withholds taxes from the wages of the auxiliary personnel.

In the office, "direct personal supervision" means the physician must be present in the same office suite, not necessarily the same room, and be available to provide immediate assistance and direction.

Outside the office, such as in a patient's home, a hospital, an emergency room, or a nursing facility, "direct personal supervision" means the physician must be present in the same room as the auxiliary person.

Nurse-midwives certified under the Iowa law are exempt from the requirement for direct personal supervision. Physician's assistants and advanced registered nurse practitioners certified under Iowa law are also exempt from this requirement. They may render service in the office setting, a hospital or a nursing facility without the physician being present. However, the physician must still be available by telephone to provide supervision and direction if required.

"Services incident to the professional service of the physician" means the service provided by the auxiliary person must be related to the physician's professional service to the patient. If the physician has not or will not perform a personal professional service to the patient, the clinical records must document that the physician has assigned the patient's treatment to the auxiliary person.

Licensed dietitians employed by or under contract with physicians may provide nutritional counseling services to recipients age 20 and under. Payment will be made to the employing physician.

In all cases, claims for services rendered by the auxiliary personnel must be submitted in the name of the employing physician. For modifier codes to be used in submitting claims, see Section VIII, **PROCEDURE CODES AND NOMENCLATURE**. Payment will be made to the physician.

## B. Routine Physical Examination

A routine physical examination is one performed without relationship to treatment or diagnosis for a specific illness, symptom, complaint, or injury. When billing these routine examinations, use diagnosis code V20.2 for children five and under and use code V70.5 for six years of age and up.

Do not bill code V70.5 for healthy patients who do not meet one of the following criteria for routine physical examinations payable under Medicaid:

- For children under 21 years of age, payment will be approved for early and periodic Care for Kids examinations. This includes all well-baby and routine physical examinations for children. Payment will be made for an annual routine physical examination for children in foster care for whom the Department assumes financial responsibility. (See Section II, Item C, **Care for Kids (EPSDT)**.)
- Payment will be approved for all children and disabled adults for a required school or camp examination. For a person age 21 and over, enter the type of examination on the claim form. Sports physicals (including Special Olympics physicals) are not covered by Medicaid. If the examination is for a child, provide and bill for a Care for Kids screening examination.
- Physical examinations in connection with a prescription for birth control medications and devices are payable. Payment will be approved for a physical examination, a pelvic examination and any other diagnostic procedure deemed necessary by the physician. For patients age 20 and under, use the GN modifier. (This does not replace a comprehensive Care for Kids examination.)
- Pap smears are payable as preventative medical services for adults age 21 and over. For patients age 20 and under, use the GN modifier. (This does not replace a comprehensive Care for Kids examination.)
- For adults age 21 and over, payment will be made for an examination which is required as a condition of employment or training approved by the Department. This includes the PROMISE JOBS Program. Enter “work program” on the claim form for these situations.
- Payment will be made for an examination made for initial and annual certifications of the need for nursing home placement, as required by regulations of the Iowa Department of Inspections and Appeals. Make an entry in the “Statement of Services” section of the claim indicating “NF initial certification” or “NF annual certification.”
- Payment will be made for the examination to establish the need for care in a residential care facility on admission and annually thereafter. Enter “RCF exam” on the claim form.

- Payment will be made for a routine physical examination for refugees who have newly settled in Iowa. Payment will be made for only one such examination per person. These refugees will have a Medical Assistance Eligibility Card.
- The Department's county office will notify the physician concerning eligibility of the refugee for a routine physical examination. The entry "refugee examination" must be shown on the claim form for persons age 21 and over. For persons age 20 and under, bill the procedure for an early and periodic "Care for Kids" screening exam.

Use preventive medicine codes for persons age 21 and over (new or established patients) only when the service rendered is a payable Medicaid service. For example, employment physicals and birth control physicals may be billed with these procedure codes. The ICD-CM diagnosis code used would normally be V70.5 (health examination of defined subpopulation) or V25.09 (family planning).

## C. Care for Kids (EPSDT)

The U.S. Department of Health and Human Services requires that the Medicaid program place special emphasis on early and periodic screening and diagnosis for children to ascertain physical and mental problems and provide treatment for conditions discovered. In Iowa, this program is called "Care for Kids."

When a child is due for a Care for Kids screening examination, the Department issues a reminder. The child's parent makes the appointment for the screening.

If a child is being examined for a preschool physical or precamp physical, provide all components of the screening examination, and bill for a Care for Kids screen, if the child has not been screened according to the recommended screening schedule. Interperiodic screens are also a covered service under Medicaid.

**1. Content of Screening Examination**

A screening examination must include at least the following:

- A comprehensive health and development history, including an assessment of both physical and mental health development. This includes:
  - A developmental assessment.
  - An assessment of nutritional status.
- A comprehensive unclothed physical examination. This includes:
  - Physical growth.
  - A physical inspection, including ear, nose, mouth, throat, teeth, and all organ systems, such as pulmonary, cardiac, and gastrointestinal.
- Appropriate immunizations according to age and health history, as recommended by the Iowa Department of Public Health.
- Health education including anticipatory guidance.
- Hearing and vision screening.
- Appropriate laboratory tests. These shall include:
  - Hematocrit or hemoglobin.
  - Rapid urine screening.
  - Lead toxicity screening for all children ages 12 to 72 months.
  - Tuberculin test, when appropriate.
  - Hemoglobinopathy, when appropriate.
  - Serology, when appropriate.
- Direct dental referral for children over the age of 12 months.

# SCREENING COMPONENTS BY AGE

| Age | Infancy | | | | | | | Early Childhood | | | | | Late Childhood | | | | | Adolescence | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2-3 [1] days | by 1 mo | 2 mo | 4 mo | 6 mo | 9 mo | 12 mo | 15 mo | 18 mo | 2 yr | 3 yr | 4 yr | 5 yr | 6 yr | 8 yr | 10 yr | 12 yr | 14 yr | 16 yr | 18 yr | 20+ yr |
| **HISTORY** | | | | | | | | | | | | | | | | | | | | | |
| Initial/Internal | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ |
| **PHYSICAL EXAM** | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ |
| **MEASUREMENTS** | | | | | | | | | | | | | | | | | | | | | |
| Height/Weight | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ |
| Head Circumference | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | | | | | | | | | | | |
| Blood Pressure | | | | | | | | | | | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ |
| **NUTRITION ASSESS/EDUCATION** | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ |
| **ORAL HEALTH** [2] | | | | | | | | | | | | | | | | | | | | | |
| Oral Health Assessment | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ |
| Dental Referral | | | | | | | ★ | | | ★ | Every six months | | | | | | | | | | |
| **SENSORY SCREENING** | | | | | | | | | | | | | | | | | | | | | |
| Vision | S | S | S | S | S | S | S | S | S | S | S | O | O | O | O | S | O | O | S | O | O |
| Hearing | O | S | S | S | S | S | S | S | S | S | S | O | O | S | S | S | O | S | S | O | S |
| **DEVELOPMENTAL AND BEHAVIORAL ASSESSMENT** [3] | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ | ★ |
| **IMMUNIZATION** [4] | ★ | | ★ | ★ | ★ | | | ★ | ★ | | | ✪ | | ★ | ★ | ★ | ✪ | | | | |
| **PROCEDURES** | | | | | | | | | | | | | | | | | | | | | |
| Hgb/Hct | | ■ | ■ | ■ | ■ | ■ | ✪ | | | | | | | | | | ✪ | ■ | ■ | ■ | ■ |
| Urinalysis | | | | | | | | | | | | | ★ | | | | ✪ | ■ | ■ | ■ | ■ |
| Metabolic screening [5] | ★ | | | | | | | | | | | | | | | | | | | | |

**KEY:** ★ To be performed ✪ Perform test once during indicated time period

**S** Subjective, by history **O** Objective, by a standard testing method

***Continued on next page.***

| | |
|---|---|
| **HEMOGLOBINOPATHY** | Only once (newborn screen) and offered to adolescents at risk. |
| **TUBERCULIN TEST** | For high-risk groups, annual testing is recommended. These are household members of persons with tuberculosis or others at risk for close contact with the disease: recent immigrants or refugees from countries in which tuberculosis is common (e.g., Asia, Africa, Central and South America, Pacific islands); migrant workers; residents of correctional institutions or homeless shelters; or persons with certain underlying medical disorders. |
| **LEAD** | Starting at 12 months, assess risk for high dose exposure. |
| **GYNECOLOGIC TESTING** | Pap smear for females who are sexually active or (if the sexual history is thought to be unreliable) age 18 or older. Pregnancy testing should be done when indicated by the history. |
| **STD** | When appropriate. (People with a history and risk factors for sexually transmitted diseases should be tested for chlamydia and gonorrhea.) |
| **ANTICIPATORY GUIDANCE** | Performed every visit. |

[1] For newborns discharged in 24 hours or less after delivery.

[2] The oral health assessment should include dental history, recent problems, pain, or injury and visual inspection of the oral cavity. Referral to a dentist should be at 12 months, 24 months, and then every 6 months, unless more frequent dental visits are recommended.

[3] By history and appropriate physical examination, if suspicious, by specific objective developmental testing.

[4] An immunization review should be performed at each screening, with immunizations being administered at appropriate ages, or as needed.

[5] The Iowa Newborn Screening program tests every baby born in Iowa for the following disorders: hypothyroidism, galactosemia, phenylketonuria, hemoglobinopathies, and congenital adrenal hyperplasia.

**2. Screening Schedule**

The recommended screening schedule is as follows:

| Child's Age | Number of Recommended Screenings | Recommended Ages for Screening |
|---|---|---|
| 0 to 12 months | 7 | *2-3 days, by 1, 2, 4, 6, 9, and 12 months |
| 13 months to 24 months | 3 | 15, 18, and 24 months |
| 3 years to 6 years | 4 | 3, 4, 5, and 6 years |
| 7 years to 20 years | 7 | 8, 10, 12, 14, 16, 18, and 20 years |

* For newborns discharged 24 hours or less after delivery.

The periodicity schedule provides a minimum basis for follow-up examinations at critical points in a child's life. Interperiodic screening, diagnosis, and treatment allows the flexibility necessary to strengthen the preventative nature of the program. Interperiodic screens may be obtained as required by foster care or educational standards and when requested for a child.

Families who accept screening receive a notice that screening is due 60 days before the recommended ages for screening. New eligibles receive a notice that screening is due immediately and then are notified according to the recommended ages.

**3. Screening Billing**

Screening examinations must be billed on form HCFA-1500, *Health Insurance Claim Form*. Use the appropriate preventive office visit code. Add modifier U1, referral for treatment during an "EPSDT" Care for Kids medical screen, if you refer the child for treatment services.

### 4. Follow-up Services

Federal regulations require that the Department maintain a record of the findings of the screening examination and follow up with the child's family to help ensure that any recommended further diagnostic studies or treatment services are received.

If the child is receiving services as a result of the findings from a screening examination, place the modifier "EP" after the procedure code.

## D. Nursing Home Screening and Evaluation

Medicaid recipients and applicants entering nursing homes (NF and SNF) are screened to determine if the person has a need related to mental illness, mental retardation, or a related condition (developmental disability). This is a Level I screening. If the person has such needs, a further evaluation is required.

This further evaluation will specifically identify the needs of the resident, so that the facility can develop a plan to meet the resident's needs. This is a Level II evaluation. These procedures are part of the Health Care Financing Administration's Preadmission Screening and Annual Resident Review (PASARR) requirements.

To bill for a Level II evaluation related to nursing home placement, use CPT codes 96100-96117 with the U4 modifier.

Procedures are paid on 15-minute units. Indicate on your claim the number of units provided. For example, one hour of direct evaluation equals four units.

## E. Nursing Home Visits

The following policies apply to visits to nursing facilities:

- Payment will usually be approved for only one visit to the same patient in a calendar month. This stipulation presumes the patient residing in a nursing home has a condition that makes a visit medically necessary. Payment for further visits will be made if you adequately substantiate the need for each visit on the claim form.
- When only one patient is seen in a single nursing home visit, payment is based on a follow-up office visit. The reason for this policy is:
  - The level of service is ordinarily comparable to that furnished in an office setting, and
  - When a larger group of patients is seen in a nursing home, the circumstances are much the same as if the nursing home were a second office.

  In the absence of information on the claim, the fiscal agent will assume that more than one patient was seen. Payment will be approved on the basis of a follow-up office call.
- Payment will be made for mileage in connection with nursing home visits under the following conditions:
  - It is necessary for the physician to travel outside the community to visit the nursing home, and
  - There are no physicians in the community in which the nursing home is located.

  If a charge is made for mileage, the circumstances must be noted on the claim. If more than one patient is seen at the nursing home, only one charge for mileage will be approved.

## F. Examination Related to Hearing Aids

### 1. Requirements

A physician must examine the recipient for any condition that would contraindicate the use of a hearing aid and complete Section A of form 470-0361, *Report of Examination for a Hearing Aid*.

**Note:** This requirement may be waived if the recipient is over 18 years of age and has signed an informed consent statement acknowledging that the recipient:

- Has been advised that it may be in the recipient's best health interest to receive a medical evaluation from a licensed physician before purchase of a hearing aid
- Does not wish to receive a medical evaluation before purchase of a hearing aid.

The physician may then do the required tests, i.e., air conduction and bone conduction tests and speech audiometry, and record the results on the 470-0361, Section B, **or** may refer the recipient to an audiologist for the testing procedures.

When referring the recipient to an audiologist not employed by the physician, give form 470-0361 to the recipient to take to the audiologist of choice for the hearing test.

### 2. 470-0361, Report of Examination for a Hearing Aid

(See following pages for a facsimile of form 470-0361.)

Iowa Department of Human Services

# REPORT OF EXAMINATION FOR A HEARING AID

**All sections of this form must be completed. Section A** indicates whether there are any reasons that would prohibit the use of a hearing aid. This section must be completed by an audiologist or a physician. **Section B** is required testing. This must be done by an audiologist who then indicates in Section C if a hearing aid evaluation may be appropriate for the recipient. **Section C** may be signed by the audiologist or by the physician.

**SECTION A. INITIAL EVALUATION**

| Patient Name | Date of Birth | Medicaid Number<br>MediPass ❑ Y ❑ N<br>Spend Down ❑ Y ❑ N | |
|---|---|---|---|
| Address | City | State | Zip |

Otoscopic Exam: Right ear ❑ Normal ❑ Excessive Cerumen Other (Explain) _____
Left ear ❑ Normal ❑ Excessive Cerumen Other (Explain) _____

Please check box if the condition is present:

- ❑ Visible congenital or traumatic deformity of the ear?
- ❑ History of /or active drainage from the ear within previous 90 days?
- ❑ Pressure or fullness feeling in the ear/s?
- ❑ Pain or discomfort in or around the ear/s, behind the ear/s?
- ❑ Sudden or rapid hearing loss within previous 90 days in one or both ears?
- ❑ Any history of noise exposure _____
- ❑ Acute or chronic dizziness, unsteadiness, lightheadedness?
- ❑ Ringing or noises in the ears/head? Describe_____
- ❑ Medical treatment or surgery of the ears OR cerumen removal? (Explain) _____
- ❑ Any known allergies? (Please list)_____
- ❑ Taking any medications? (Please list) _____
- ❑ Diabetic? Yes_____ No_____
- ❑ Familial history of hearing loss? (Explain) _____

Suspected cause of hearing loss:_____

Comments: _____

Recommendation for further care: _____ Audiologist for testing _____ Otologist/ENT

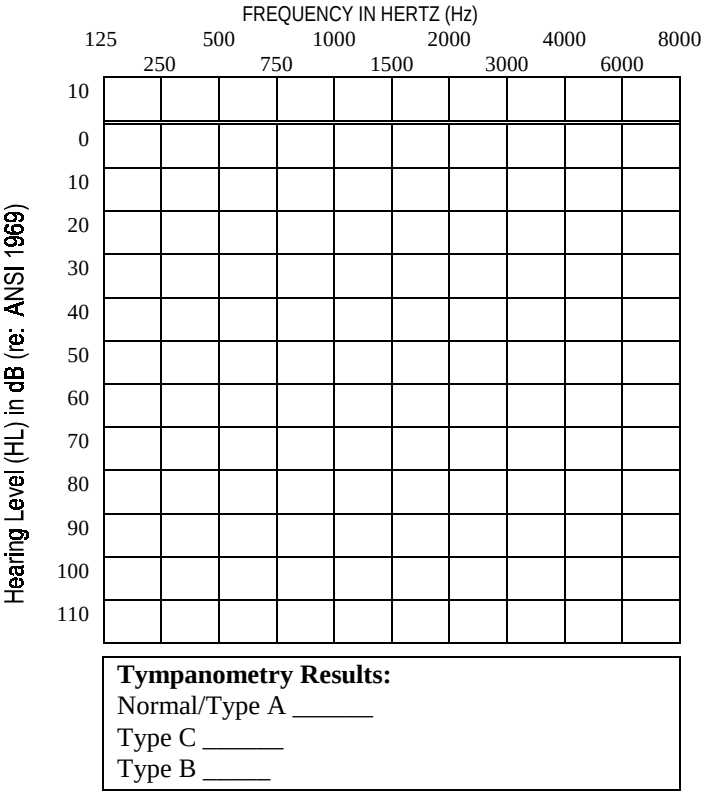
| Signature of Physician/Audiologist | Date |
|---|---|
| | |

Please print or type Physician's/Audiologist's name and address

**The information requested on this form must be maintained within the patient's records**

**SECTION B. AUDIOLOGIC EVALUATION**

| Name of Tester/Audiologist | Name of Practice |
|---|---|
| Street | City State Zip |




**Tympanometry Results:**
Normal/Type A _____
Type C _____
Type B _____

SPEECH AUDIOMETRY (Re ANSI. 1969)

| | SRT | MASK | Word Recognition Scores | | | | |
|---|---|---|---|---|---|---|---|
| | | | % | HL | MASK | MCL | UCL |
| R | | | | | | | |
| L | | | | | | | |
| SF | | | | | | | |
| AIDED | | | | | | | |

| | |
|---|---|
| Audiometer: | LIVE ❑ |
| Test Reliability: | Recorded ❑ |

| LEGEND: | RIGHT | LEFT |
|---|---|---|
| AIR CONDUCTION | O | X |
| Masked Results | Δ | □ |
| BONE CONDUCTION | < | > |
| Masked Results | [ | ] |
| NO RESPONSE | ↓ | ↓ |

Remarks

If standard audiological procedures, are not appropriate for this patient please attach additional comments explaining what test procedures were used, along with the results.

**SECTION C. RECOMMENDATIONS (To be completed by audiologist or physician after testing.)**

| | |
|---|---|
| ❑ Hearing aid evaluation recommended | ❑ Medical referral – ENT/Otologist |
| ❑ No hearing aid evaluation recommended | ❑ Medical Waiver Allowed |
| ❑ Medical Clearance Received | ❑ Other (explain) |

| Date | Signature of Audiologist/Physician |
|---|---|
| | |

## G. Prenatal Risk Assessment

Medicaid-eligible pregnant women shall have a determination of risk using form 470-2942, *Medicaid Prenatal Risk Assessment*, upon entry into care. Form 470-2972 was developed jointly by the Departments of Human Services and Public Health. It was designed to help clinicians determine which pregnant clients are in need of supplementary services to complement and support routine medical prenatal care.

Keep a copy of form 470-2942 in the patient's medical records. See VII. D, **Obstetrical Services**, for billing instructions.

When a low-risk pregnancy is reflected, complete a second determination at approximately 28 weeks of care or when you determine there is an increase in the pregnant woman's risk status.

When a high-risk pregnancy is reflected, inform the woman and provide a referral for enhanced services. Give a copy of form 470-2942 to the enhanced services agency.

### 1. Referral for Enhanced Services

See VI.C, **Enhanced Services for High-Risk Pregnant Women**, for a definition of enhanced services and the referral process. The primary medical care provider continues to provide the medical care. Maternal health centers work with physicians to provide enhanced services for higher risk pregnant women. This process allows these patients to access additional services that Medicaid does not provide under other circumstances.

The services included in Medicaid enhanced services for pregnant women are recommended in a 1989 report of the United States Public Health Services Expert Panel on the Content of Prenatal Care, Caring For The Future: The Content of Prenatal Care.

National studies have shown that low-income women who receive these enhanced services along with medical prenatal care have improved birth outcomes. This package of services is aimed at promoting better birth outcomes for Medicaid-eligible pregnant women in Iowa.

**2. How to Use the Risk Assessment Form**

The left side of form 470-2972, *Medicaid Prenatal Risk Assessment*, includes risk factors relating to medical, historical, environmental, or situational factors. A description of many of the risk factors is included on the back of the form.

The factors on the left side are categorized and the score value is related to the seriousness of the risk (for example age, education, and prepregnancy weight). You may determine that the value assigned on the form is not appropriate for this patient and may choose a lesser value.

Give cigarette smoking point value if the person smokes one cigarette or more per day. If secondary smoke is a risk factor, indicate it under "Other."

Indicate the risk factor 'Last birth within 1 year' when the patient has been pregnant within one year of the beginning of the present pregnancy.

The right side of the form includes risk factors related to the current pregnancy. Some of these factors are described on the back of the form. These factors are more likely to change during the pregnancy. They may be present during the initial visit or may not appear until the middle or last trimester. For this reason, these risk factors are assessed twice during the pregnancy.

To determine the patient's risk status during the current pregnancy, add the total score value on the left side and either the B1 column (score value at the initial visit) or the B2 column (score value at a visit between 24 and 28 weeks gestation) to obtain the total score. A total score of 10 meets the criteria for high risk on this assessment.

You can use the "Other" box to indicate other risk factors present in the pregnancy, but not reflected in the earlier sections. Examples of other risk factors are listed on the back of the form. These are common examples only and are not meant to be a comprehensive list.

**3. Facsimile of 470-2942, Medicaid Prenatal Risk Assessment**

(See following pages for a facsimile of this form.)

Iowa Department of Human Services

# MEDICAID PRENATAL RISK ASSESSMENT

| Primary provider name | Medicaid provider number | Provider phone number |
|---|---|---|
| Client name | Phone number | Client date of birth |
| Address | | Medicaid ID number |

Gestational age at initial assessment: Weeks Date

Gestational age at rescreen: Weeks Date

**Instructions:** Write the score that applies to each risk factor. (* For risk factor definitions and nutrition screen, see back.)

| Risk Factor/Value | A Score Initial |
|---|---|
| Maternal age<br>20-40 = 0 16-19 or >40 = 4 ≤ 15 = 10 | |
| Education<br>GED or 12 = 0 ≤ 11 = 2 | |
| Marital status<br>married = 0 single, divorced, separated = 2 | |
| Height<br>>5 feet = 0 ≤ 5 feet = 3 | |
| Prepregancy weight<br>low (BMI < 19.8) = 2 obese (BMI > 29.0) = 2 | |
| AB 1st trimester *<br>< 3 = 0 ≥ 3 = 1 | |
| AB 2nd trimester *<br>none = 0 1 = 5 ≥ 2 = 10 | |
| Race<br>white = 0 black = 2 other = 1 | |
| Cone biopsy<br>no = 0 yes = 3 | |
| Uterine anomaly *<br>no = 0 yes = 10 | |
| Previous SGA baby<br>no = 0 yes = 10 | |
| Hx preterm labor * or preterm delivery<br>no = 0 yes = number x 10 | |
| Hx of gum disease<br>no = 0 yes = 3 | |
| Cigarette use/day<br>1 cig – 1/2 ppd = 1 > 1/2 ppd = 4 | |
| Street drug use * (this pregnancy)<br>no = 0 yes = 5 | |
| Alcohol use * (this pregnancy)<br>no = 0 yes = 2 | |
| Initial prenatal visit *<br>< 16 wks = 0 > 16 wks = 2 | |
| Poor social situation *<br>no = 0 yes = 5 | |
| Children ≤ 5 years at home<br>0 or 1 = 0 ≥ 2 = 2 | |
| Employment *<br>none = 0 outside work = 1 heavy work = 3 | |
| Last pregnancy within 1 year of present pregnancy<br>no = 0 yes = 1 | |
| **Subtotal A** | |

| Risk Factor Current Pregnancy/Value | B1 Initial OB | B2 Rescreen 28 wks+ |
|---|---|---|
| Bacteriuria,* chlamydia, GC this pregnancy<br>no = 0 yes = 3 | | |
| Pyelonephritis *<br>no = 0 yes = 5 | | |
| Fibroids<br>no = 0 yes = 3 | | |
| Presenting part engaged < 36 weeks<br>no = 0 yes = 3 | | |
| Uterine bleeding ≥ 12 weeks *<br>no = 0 yes = 4 | | |
| Cervical length < 1 cm < 34 weeks<br>no = 0 yes = 4 | | |
| Dilation ≥ 1 cm *<br>no = 0 yes = 4 | | |
| Uterine irritability * ≤ 34 weeks<br>no = 0 yes = 4 | | |
| Placenta previa at < 30 weeks<br>no = 0 yes = 4 | | |
| Oligohydramnios<br>no = 0 yes = 10 | | |
| Polyhydramnios<br>no = 0 yes = 10 | | |
| Multiple pregnancy<br>no = 0 yes = 10+ | | |
| Surgery (abdominal * ≥ 18 weeks or cerclage)<br>no = 0 yes = 10 | | |
| Febrile illness *<br>no = 0 yes = 3 | | |
| Weight gain at 22 weeks<br>≥ 7 lb. = 0 < 7 lb. = 2 | | |
| Weight loss<br>< 5 lb. = 0 ≥ 5 lb. = 3 | | |
| Urine protein<br>0/trace = 0 1+ = 2 > 1+ = 5 | | |
| Hypertension * or HTN medications<br>no = 0 yes = 10 | | |
| Hemoglobin Hematocrit<br>< 11 = 3 < 30 = 3 | | |
| **Subtotal B1 and B2** | | |

| | | | |
|---|---|---|---|
| Subtotal A | | Subtotal A | |
| Subtotal B1 | + | Subtotal B2 | + |
| Total 1st OB | | Total 28 weeks screen | |

Other: _____ Additional risk factors indicating need for enhanced services. (See back for examples.) Points need not total 10.

**Total score of 10 points or more = high risk for preterm delivery.**
Check all enhanced antepartum management services that apply and indicate who will be the primary provider of each service.

- ❑ Home visit _____
- ❑ Care coordination _____
- ❑ Health education II _____
- ❑ Psychosocial _____
- ❑ High risk follow-up _____
- ❑ Nutrition counseling _____

Signature of primary provider Date

Client signature: Release of information Date

Date of referral for WIC services:
(State WIC Office – 1-800-532-1579)

| Risk Factor Definition |
|---|
| **AB 1st trimester:** More than three spontaneous or induced abortions at less than 13 weeks gestation. (Do not include ectopic pregnancies.) |
| **AB 2nd trimester:** Spontaneous or induced abortion between 12 and 19 weeks gestation. |
| **Uterine anomaly:** Bicornate, T-shaped, or septate uterus, etc. |
| **DES exposure:** Exposure to diethylstilbesterol in utero. Patient who has anomalies associated with diethylstilbesterol receives points for this item and uterine anomaly. |
| **Hx PTL:** Spontaneous preterm labor during any previous pregnancies (whether or not resulting in preterm birth) or preterm delivery. |
| **Hx pyelonephritis:** One or more episodes of pyelonephritis in past medical history. |
| **Street drug use:** Any street drug use during this pregnancy, e.g., speed, marijuana, cocaine, heroin (includes methadone). |
| **Alcohol use:** Consumption of 6 or more glasses of beer or wine per week or 4 or more mixed drinks per week. Includes any binge drinking. |
| **Initial prenatal visit:** First prenatal visit at or after 16 weeks gestation. |
| **Poor social situation:** Personal or family history of abuse, incarceration, homelessness, psychiatric disorder, child custody loss, cultural barriers, low cognitive functioning, mental retardation, negative attitude toward pregnancy, exposure to hazardous/toxic agents, inadequate support system. |
| **Employment:**<br>Light work = part time or sedentary work<br>Heavy work = work involving strenuous physical effort, standing, or continuous nervous tension, such as, nurses, sales staff, cleaning staff, baby-sitters, laborers |
| **Bacteriuria:** Any symptomatic or asymptomatic urinary tract infection, i.e., 100,000 colonies in urinalysis. |
| **Pyelonephritis:** Diagnosed pyelonephritis in the current pregnancy. (Give points for pyelonephritis only, not both pyelonephritis and bacteriuria.) |
| **Bleeding after 12th week:** Vaginal bleeding or spotting after 12 weeks of gestation of any amount, duration, or frequency which is not obviously due to cervical contact. |
| **Dilation (Internal os):** Cervical dilation of the internal os of one cm or more at 34 weeks gestation. |
| **Uterine irritability:** Uterine contractions of 5 contractions in one hour perceived by patient or documented by provider without cervical change at less than 34 weeks. |
| **Surgery:** Any abdominal surgery performed at 18 weeks or more of gestation or cervical cerclage at any time in this pregnancy. |
| **Febrile illness:** Systemic illness (such as pyelonephritis or influenza) with temperature of 100° F or greater determined by thermometer reading on one or more occasions. |
| **Hypertension:** Two measurements showing an increase of systolic pressure of 30 mgHg above baseline, an increase in diastolic pressure of 15 mgHg above baseline, or both. |

## Nutritional Risk Factor Assessment and Definitions

**Instructions:** Check nutrition counseling if any of the factors below indicate nutritional risk.

**Anemia:** Hematocrit is < 31 or hemoglobin is < 11.

**Inadequate Food Intake:** Determine nutritional risk by diet history (foods typically eaten in a day).Use this risk factor if deficient in two or more groups.

| Food Group | Number Servings Recommended |
|---|---|
| **Milk:** (includes milk, cheese, yogurt, cottage cheese, etc.) | 3 |
| **Meat or Alternates:** (includes meats, fish, poultry, eggs, nuts, legumes, peanut butter, etc.) | 2-3 (total of 6 oz. per day) |
| **Breads and Cereals:** (includes breads, cereal, pasta, rice, etc.) | 6-11 |
| **Vegetables:** (includes broccoli, tomatoes, cabbage, baked potato, carrots, squash, sweet potato, etc.) For **Vitamin A,** include dark green and yellow vegetables. | 3-5 |
| **Fruits:** (includes oranges, grapefruits, melons, berries, apples, grapes, etc.) For **Vitamin C,** include citrus fruit and juices. | 2-4 |

## Examples of additional risk factors:

| | |
|---|---|
| Medical | ♦ Thyroid disease<br>♦ Type I diabetes<br>♦ Renal disease<br>♦ Heart disease<br>♦ Diabetes<br>♦ HIV<br>♦ Autoimmune disease<br>♦ Seizure disorders<br>♦ Gestational diabetes<br>♦ Psychiatric disorder |
| OB History | ♦ Infertility<br>♦ Perinatal loss<br>♦ Caesarean section |
| Nutrition | ♦ Diet deficient in two or more food groups<br>♦ Vegan diet (consumes **only** fruits, vegetables and grains)<br>♦ Pica<br>♦ Current eating disorder<br>♦ Hyperemesis<br>♦ Food faddism<br>♦ Excessive use of supplements |
| Psychosocial | ♦ Teen pregnancy<br>♦ Ambivalent, denying, or rejecting of this pregnancy<br>♦ Not compliant with healthy pregnancy behaviors (or not expected to be compliant without additional intervention)<br>♦ Cultural or language barriers<br>♦ History of mental illness |

# H. Prescription of Medical Supplies and Equipment

## 1. Medical and Sickroom Supplies

Most medical and sickroom supplies are covered when ordered by a physician and supplied by a medical item supplier for a specific rather than an incidental use. Certain items require specific documentation from the physician to substantiate medical necessity before reimbursement can be made to the dealer for the items.

No payment will be made for medical and sickroom supplies for a recipient receiving care in a Medicare-certified skilled nursing facility. For a recipient receiving care in a nursing facility or intermediate care facility for the mentally retarded, payment will be approved only for the following (when prescribed by the physician):

- Colostomy and ileostomy appliances.
- Colostomy and ileostomy care dressings, liquid adhesive, and adhesive tape.
- Disposable irrigation trays or sets (sterile).
- Disposable catheterization trays or sets (sterile).
- Catheters (indwelling Foley).
- Disposable saline enemas (sodium phosphate type, for example).
- Diabetic supplies (needles and syringes, disposable or reusable; test-tape, clinitest tablets, and clinistix).
- Nutritional supplements and supplies (when approved).

## 2. Orthopedic Shoes, Appliances, and Prosthetic Devices

Payment will be made to medical appliance and orthopedic shoe dealers for items on the written prescription of the physician. Several items of medical equipment require specific documentation from the physician to substantiate medical necessity before reimbursement can be made to the dealer for the items. (Diagnosis of flat feet is not acceptable.)

Payment will also be made to shoe repair shops performing modifications on orthopedic shoes when the physician prescribes such modifications in writing. The physician's prescription must include:

- The patient's diagnosis and prognosis (for custom-made shoes only).
- The reason the item is required.
- An estimate (in months) of the duration of the need.
- A specific description of any special features to be included (e.g., padding, wedging, metatarsal bars, build-up soles or heels).

Payment will be made to the physician for the examination, including required tests, to establish the need for orthopedic shoes. Tennis shoes are covered only when required for participation in school sport activities.

Medical supplies payable to a physician are limited to those incident to a physician's service and for which the patient cannot be expected to leave the physician's office and go to a supplier.

No payment will be approved for walkers, wheelchairs, special beds, or other sickroom equipment for recipients receiving care in a nursing facility.

### 3. Nutritional Supplements

For enteral products and supplies, the dispensing provider must submit these to the fiscal agent with form 470-0829, *Request for Prior Authorization*. Prior authorization is no longer required for parenteral therapy.

For nutritional supplements and supplies for administering the nutritional supplements, the physician must prescribe the item and document the medical necessity.

Prescription or nonprescription nutritional supplements shall be approved for payment for a recipient who needs the supplement due to a specifically diagnosed disease or digestive disorder that prevents the person from

obtaining the necessary nutritional value from usual foods and which cannot be managed by avoidance of certain food products. The information submitted must identify other methods attempted to support the recipient's nutritional needs. The documentation indicating the patient's condition must be sufficient to meet the above requirements.

When nutritional supplements are approved, reasonable supplies to administer nutritional supplements are also covered.

This policy applies to recipients in their own homes or in a nursing facility, since the items in this section are also considered prosthetic devices.

**Note:** Nutritional Supplementation Some recipients require supplementation of their daily protein and calorie intake. Nutritional supplements are often given as a medicine between meals to boost protein or calorie intake. Medicaid does not cover nutritional supplementation.

## I. Optical Services

### 1. Eye Exams

Routine eye examinations are covered once in a 12-month period. Eye examinations are also covered if the exam is the result of a complaint or symptom of an eye disease or injury. (When exams have been provided as a result of a complaint or symptom of an eye disease or injury, the claim must identify and describe the complaint, symptom, or injury for which the exam was rendered.).

Single tonometry is part of the intermediate and comprehensive exams and is not a separate payable procedure. Serial tonometry is a payable benefit.

Gross visual fields are part of the intermediate and comprehensive exams and are not separate payable procedures.

Prior approval is not required for tonometry and visual fields.

**2. Eyeglasses and Contact Lenses**

Physicians dispensing eyeglasses and contact lenses are subject to the same requirements as optometrists and opticians. See Section VIII.F for procedure codes and modifiers.

Materials that are payable by a fee schedule are: lenses, including single vision and multifocal; frames; and case for glasses.

Materials that are payable at actual laboratory cost, as evidenced by an attached invoice, are: contact lenses, Schroeder shield, ptosis crutch, protective lenses for a person with only one eye (even if a corrective lens is not required), and subnormal visual aids.

Noncovered eyeglasses and contacts include: glasses with cosmetic gradient, tinted lenses, or other eyewear for cosmetic purposes; glasses for protective purposes, including glasses for eye safety, sunglasses, or glasses with photogray lenses, unless the protective lenses are for a person with only one eye, even if a corrective lens is not required; a second pair of glasses or spare glasses; and contact lenses if vision is correctable with noncontact lenses.

Prior authorization is required for subnormal visual aids where near visual acuity is better than 20/100 at 16 inches, 2M print. Prior authorization is not required if near visual acuity as described above is less than 20/100. Subnormal visual aids include, but are not limited to, hand magnifiers, loups, telescopic spectacles, or reverse Galilean telescope systems. Payment shall be actual laboratory costs, as evidenced by an attached invoice. If a second pair of eyeglasses is prescribed for a recipient within 24 months, the physician shall request prior authorization from the fiscal agent. The eyeglasses shall be approved if the recipient's vision has at least a .5-diopter of change in sphere or cylinder or 10-degree change in axis in

either eye. Glasses that are lost or broken beyond repair may be replaced at any time. However, that information must be entered on the claim by using modifier "RP" after the procedure code.

Contact lenses are covered only when required following cataract surgery or documented keratoconus or for treatment of acute or chronic eye disease.

Some laboratories have agreed to accept Iowa Medicaid fees. Check with the laboratories that serve you to determine if they will provide the lenses at the established fees.

**3. Visual Therapy**

Prior authorization is required for visual therapy. The fiscal agent may authorize visual therapy when warranted by case history or diagnosis, for a period not greater than 90 days. Should continued therapy be warranted, request prior approval again. Include a report showing satisfactory progress. Approved diagnoses are convergence insufficiency and amblyopia.

## J. Laboratory and Radiological Services

Independent laboratories and radiological services are eligible to participate in the Medicaid program if they are certified eligible to participate in Medicare. A physician may bill the Medicaid program for laboratory or radiological services rendered in the physician's office under the physician's personal supervision.

For billing purposes, laboratory and radiology services performed in an outpatient or inpatient setting must indicate the 26 modifier directly after the procedure code, unless the procedure code already represents interpretation only. Use the TC modifier when you are performing only the technical component of a radiological procedure, and another physician is performing the professional component.

## K. Routine Venipuncture

Code 36415 (routine venipuncture) is payable when the blood specimen is drawn at the physician's office and the test is performed in the physician's office. Continue to use code 99000 when the specimen is collected at the physician's office and then sent to an outside lab for testing. Codes 36415 and 99000 cannot both be billed on the same date of service; bill one or the other.

## L. Nutritional Counseling

Nutritional counseling services provided by licensed dietitians for recipients age 20 and under when a nutritional problem or a condition of such severity exists that nutritional counseling beyond that normally expected as part of the standard medical management is warranted.

Medical conditions that may be appropriate for nutritional counseling include the following:

- Inadequate or excessive growth. Examples include failure to thrive, undesired weight loss, underweight, major changes in weight-to-height percentile or BMI for age.
- Inadequate dietary intake. Examples include formula intolerance, food allergy, limited variety of foods, limited food resources, and poor appetite.
- Infant feeding problems. Examples include poor suck/swallow, breastfeeding difficulties, lack of developmental feeding progress, inappropriate kinds or amounts of feeding offered, and limited information or skills of caregiver.
- Chronic disease requiring nutritional intervention. Examples include congenital heart disease, pulmonary disease, renal disease, cystic fibrosis, metabolic disorder, and gastrointestinal disease.
- Medical conditions requiring nutritional intervention. Examples include iron deficiency anemia, high serum lead level, familial hyperlipidemia, hyperlipidemia, and pregnancy.

- Developmental disability. Examples include increased risk of altered energy and nutrient needs, oral-motor or behavioral feeding difficulties, medication-nutrient interaction, tube feedings.
- Psychosocial factors. Examples include behaviors suggesting an eating disorder.

This is not an all-inclusive list. Other diagnosis may be appropriate.

Individuals eligible for nutritional counseling through the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) must provide a statement that the need for nutritional counseling exceeds the services available through WIC. Submit a copy of this statement with the claim.

## M. Excluded Services

### 1. Treatment of Certain Foot Conditions

#### a. Flat Foot

The term "flat foot" is defined as a condition in which one or more arches have flattened out. Services directed toward the care or correction of such conditions are not covered. (For exceptions for orthopedic shoes, see Section II, Item H, **Prescription of Medical Supplies and Equipment**.)

#### b. Subluxations of the Foot

"Subluxations of the foot" are defined as partial dislocations or displacements of joint surfaces, tendons, ligaments or muscles of the foot. Surgical or nonsurgical treatments undertaken for the sole purpose of correcting a subluxated structure in the foot as an isolated entity are not covered. (For exceptions for orthopedic shoes, see section II. H, **Prescription of Medical Supplies and Equipment**.)

Reasonable and necessary diagnosis and treatment of symptomatic conditions such as osteoarthritis, bursitis (including bunion), tendonitis, etc., that result from or are associated with partial displacement of foot structures are covered services.

Surgical correction of the subluxated foot structure that is an integral part of the treatment of a foot injury or that is undertaken to improve the function of the foot or to alleviate an induced or associated symptomatic condition is a covered service.

**c. Routine Foot Care**

Routine foot care includes:

- The cutting or removal of corns or calluses.
- The trimming of nails.
- Other hygienic or preventive maintenance care in the realm of self-care, such as:
  - Cleaning and soaking the feet.
  - The use of skin creams to maintain skin tone of both ambulatory and bedfast patients.
  - Any services performed in the absence of localized injury, illness, or symptoms involving the foot.

Foot care such as routine soaking and application of topical medication on a physician's order between required visits to the physician is not covered.

The nonprofessional performance of certain foot care procedures otherwise considered routine, such as cutting or removal of corns, calluses or nails, can present a hazard to patients with certain disease processes.

If such a procedure does present a hazard to the patient, it is not considered routine when:

- The patient is under the care of a doctor of medicine or osteopathy, or
- There is a systemic disease such as diabetes mellitus, or
- Other conditions have resulted in circulatory embarrassment or areas of desensitization in the legs or feet.

When services have been rendered, the claim *must* identify and describe the complicating systemic disease that makes rendition of the routine service by a nonprofessional hazardous.

**Note:** The removal of warts is not considered routine. Payment *will* be made for wart removal.

**2. Acupuncture Treatments**

Acupuncture treatments are not covered, whether for anesthetic, analgesic or therapeutic purposes.

# III. PRESCRIPTION OF DRUGS

Payment will be made for drugs as described below when prescribed by a legally qualified practitioner (which includes physician, dentist, podiatrist, physician assistant, therapeutically certified optometrist, or advanced registered nurse practitioner).

Payment will be made for drugs dispensed by a physician only if there is no licensed retail pharmacy in the community where the physician's office is located. If you are eligible to dispense drugs, request a copy of the ***Prescribed Drugs Manual*** from the fiscal agent.

## A. Legend Drugs and Devices

Payment will be made for drugs and devices (e.g., diaphragms) requiring a prescription by law with the following exceptions:

- Drugs not marketed by manufacturers that have a signed Medicaid rebate agreement.
- Drugs prescribed for a use other than the drug's medically accepted use.
- Drugs used to cause anorexia or weight gain.
- Drugs used for cosmetic purposes or hair growth.

- Drugs used to promote smoking cessation.
- Covered outpatient drugs for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or the manufacturer's designee.
- Drugs classified as less than effective by the Health Care Financing Administration.
- Drugs which require a prior authorization as specified under **III. B. Drugs Requiring Prior Approval of the Fiscal Agent**.
- Drugs used for fertility purposes.

Payment will also be made for insulin on a legally qualified practitioner's prescription, although a prescription is not legally required.

## B. Drugs Requiring Prior Approval of the Fiscal Agent

Payment for drugs requiring a prior authorization will be made only when:

- The drugs are prescribed for treatment of one or more of the conditions set forth for each drug, and
- Approval is obtained through the fiscal agent.

Prior authorization may be requested via telephone, FAX, or mail, to the Unisys Drug Prior Authorization Unit. The physician or pharmacist shall use the *Request for Medicaid Drug Prior Authorization*, form 470-2961, for this purpose. The request requires the information designated on form 470-2961, including the diagnosis and total medical condition of the patient. Instructions for completing form 470-2961 are found in Chapter F.

A decision by the pharmacist reviewer and response will be made within 24 hours of the request. Requests received after regular working hours (8:30 a.m. to 5:30 p.m.) or on weekends will be considered to be received at the start of the next working day. If the after hours or weekend request is for an emergency situation, reimbursement will be made for a 72-hour supply.

The following classes of drugs require prior approval:

- Amphetamines, combinations of amphetamines with other agents, and amphetamine-like sympathomimetic compounds.
- Cephalexin hydrochloride monohydrate.
- Dipyridamole.
- Epoetin (Epogen).
- Filgrastim (Neupogen).
- Growth hormones.
- Histamine $H_2$-receptor antagonists and sucralfate at full therapeutic dose.
- Legend and nonlegend multiple vitamins, tonic preparations and combinations with minerals, hormone, stimulants.
- Legend topical anti-acne products.
- Misoprostol.
- Non-sedating antihistamines.
- Proton pump inhibitors.
- Single-source benzodiazepines.
- Single-source nonsteroidal anti-inflammatory drugs.
- Topical tretinoin (Retin A™ Products).
- Selected brand name drugs as determined by the Department for which there is available an "A" rated bioequivalent generic product.

Many of the persons for whom Medicaid coverage is available may be receiving case management services. Case managers are aware of the prior authorization process, and are cognizant of the fact that the patient may not be able to initiate the prior authorization process independently. The case manager may have responsibility for setting the appointments for the person and may have first-hand contact with the treating physician.

**Note:** Be sure to notify the pharmacy of the prior approval number, since the pharmacy will need the number to submit its claim. One approval covers an uninterrupted course of therapy for a patient. An "uninterrupted course of therapy" is a period in which any discontinuance of the drug is for no longer than seven days. Payment will be made to only one pharmacy for the uninterrupted course of therapy.

The specific criteria for approval of a prior authorization request are defined in the subsections that follow.

### 1. Amphetamines

Prior authorization is required for amphetamines, combinations of amphetamines with other therapeutic agents, and amphetamine-like sympathomimetic compounds used for obesity control, including any combination of such compounds with other therapeutic agents. Examples are: amphetamines, Dexedrine, Preludin, and Tenuate.

Payment for amphetamines will be authorized upon telephoned, FAXed, or written request by the physician or pharmacist to the fiscal agent only for those cases in which there is a diagnosis of:

- Narcolepsy.
- Hyperkinesis in children.
- Senile depression.

Prior authorization will *not* be granted for a diagnosis of obesity control. The request must also state the reason that drugs now available for payment under the program are not satisfactory for treatment of the condition.

**2. Cephalexin Hydrochloride Monohydrate**

Prior authorization is required for all cephalexin hydrochloride monohydrate therapy. Payment for cephalexin hydrochloride monohydrate therapy will be authorized only when there is documentation of previous trial and therapy failure with cephalexin monohydrate.

**3. Dipyridamole**

Prior authorization is required for dipyridamole therapy, including the innovator of the multiple-source product and the multiple-source products. Payment for dipyridamole therapy will be authorized only where there is documentation of a medical contraindication of the use of aspirin.

**4. Epoetin**

Prior authorization is required for therapy with epoetin. Payment for epoetin therapy will be authorized only for cases which meet all of the following criteria:

- Hematocrit is less than 30 percent.
- Transferrin saturation is greater than 20 percent or ferritin levels greater than 100ng/ml. (Exceptions may be made if the patient is on aggressive oral iron therapy (dosed two to three times per day).)
- These laboratory values are dated within three months of the prior authorization request.
- There is no evidence of demonstrated GI bleeding.
- Patients concurrently on AZT have an endogenous serum erythropoietin level less than or equal to 500 mU/ml.

### 5. Filgrastim

Prior authorization is required for therapy with filgrastim. Payment for filgrastim therapy will be authorized only for those cases which meet one of the following indications and satisfy each of the related criteria:

- *Indication*: To decrease the incidence of infection due to severe neutropenia caused by myelosuppressive anti-cancer therapy.
  - Criterion 1. Post nadir ANC is less than 10,000 cells/$mm^3$.
  - Criterion 2. Routine CBC and platelet counts twice weekly.

- *Indication*: To decrease the incidence of infection due to severe neutropenia in AIDS patients on zidovudine therapy.
  - Criterion 1. Evidence of a neutropenic infection exists or ANC is below 750 cells/$mm^5$.
  - Criterion 2. ANC is maintained at approximately 1,000 cells/$mm^3$ by filgrastim adjustment.
  - Criterion 3. Routine CBC and platelet counts weekly.

### 6. Growth Hormones

Prior authorization is required for therapy with growth hormones. Payment for growth hormones will be authorized only for those cases which meet each of the following criteria:

- Standard deviation of 2.0 or more below mean height for chronological age.
- No intracranial lesion or tumor diagnosed by MRI.
- Growth rate below five centimeters per year.
- Failure of any two stimuli tests to raise the serum growth hormone level above seven nanograms/milliliter.
- Bone age 14-15 years or less in females, and 15-16 years or less in males.
- Epiphyses open.

### 7. Histamine $H_2$-Receptor Antagonists and Sucralfate

Prior authorization is *not* required for maintenance doses of these drugs or for a cumulative 90 days of therapy at full therapeutic dose levels per 12-month period per recipient.

Prior authorization is required for histamine $H_2$-receptor antagonists and sucralfate at full therapeutic dose levels for longer than a 90-day period. Payment for histamine $H_2$-receptor antagonists at full therapeutic dose levels beyond the 90-day limit or more frequently than one 90-day course per patient per 12-month period, will be authorized only for those cases in which there is a diagnosis of:

- Hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis, multiple endocrine adenomas).
- Symptomatic gastroesophageal reflux (not responding or failure by maintenance therapy).
- Symptomatic relapses (duodenum or gastric ulcer) on maintenance therapy.
- Barrettes esophagus.
- Other conditions will be considered on an individual basis.

Sucralfate prescribed concurrently with histamine $H_2$-receptor antagonists for a period exceeding 30 days will be considered duplicative and inappropriate. Omeprazole or misoprostol prescribed concurrently with histamine $H_2$-receptor antagonists will be considered duplicative and inappropriate.

### 8. Legend and Nonlegend Vitamins and Minerals

Payment for multiple vitamins will be authorized only for:

- Patients with a diagnosis of specific vitamin deficiency disease.
- Patients under the age of 21 with a diagnosed disease which inhibits the nutrition absorption process as a secondary effect of the disease.

The request must also state the reason that drugs now available for payment under Medicaid are not satisfactory for treatment of the condition.

Prior authorization is not required for a product primarily classified as a blood modifier, if that product does not contain more than three vitamins. Some examples are Fero-Folic 500 and Trinsicon.

Prior authorization is not required for a vitamin and mineral product principally marketed for use as a dietary supplement during pregnancy and lactation.

### 9. Legend Topical Anti-Acne Products

Prior authorization is *not* required for *nonlegend* topical acne products for the treatment of acne vulgaris. Please consult the OTC payable list for current information on covered products. See below for prior authorization for topical tretinoin products.

Prior authorization is required for all *legend* topical acne products for the treatment of acne vulgaris. The definition of legend topical acne products includes all topical products for the treatment of acne vulgaris, including multiple-source and single-source products.

Payment for prescription topical anti-acne products will be authorized only for cases in which there is documentation of previous trial and therapy failure with at least one non-legend benzoyl peroxide product.

**10. Misoprostol**

Prior authorization is *not* required when a nonsteroidal anti-inflammatory drug is prescribed concurrently. Prior authorization is *not* required for 90 days of therapy without a concurrent nonsteroidal anti-inflammatory drug.

Prior authorization is required for therapy without a concurrent nonsteroidal anti-inflammatory drug beyond the 90-day limit. Payment will be authorized only on an individual basis. Misoprostol prescribed concurrently with histamine $H_2$-receptor antagonists will be considered duplicative and inappropriate.

**11. Nonsedating Antihistamines**

Prior authorization is not required for those antihistamines which are not classified as "nonsedating." This includes legend and nonlegend antihistamines currently covered under the Medicaid program.

Prior authorization is required for legend antihistamines classified as "non-sedating." Payment for a nonsedating antihistamine will be authorized only where there is documentation of previous trials and therapy failure with at least two other covered antihistamines, such as chlorpheniramine or diphenhydramine.

**12. Proton Pump Inhibitors**

Prior authorization is not required for a cumulative 60 days of therapy with a proton pump inhibitor per 12-month period per recipient. The 12-month period is patient-specific and begins 12 months before the requested date of prior authorization.

Prior authorization is required for proton pump inhibitor usage longer than 60 days or more frequently than one 60-day course per 12-month period. Payment for usage of proton pump inhibitors beyond these limits will be authorized for cases in which there is a diagnosis of:

- Symptomatic gastroesophageal reflux after documentation of previous trials and therapy failure with at least one histamine $H_2$-receptor antagonist at full therapeutic doses as defined by the histamine $H_2$-receptor antagonist prior authorization guidelines.

- Barretts esophagus.
- Specific hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis, multiple endocrine adenomas).
- Recurrent peptic ulcer disease after documentation of previous trials and therapy failure with at least one histamine $H_2$-receptor antagonist at full therapeutic doses and with documentation of either failure of *Helicobacter Pylori* treatment or a negative *Helicobacter Pylori* test result.

Proton pump inhibitors prescribed concurrently with histamine $H_2$-receptor antagonists will be considered duplicative and inappropriate.

The medical condition of patients receiving continuous long-term treatment with proton pump inhibitors will be reviewed yearly to determine the need for ongoing treatment.

**13. Single-Source Benzodiazepines**

Prior authorization is required for single-source benzodiazepines, unless the patient was established on a single-source benzodiazepine product before October 1, 1992. Prior authorization is *not* required for multiple-source benzodiazepines.

Included in the definition of "single-source" is the innovator of a multiple-source drug, or "brand name." Payment for a single-source benzodiazepine product will be authorized only for cases in which there is documentation of previous trials and therapy failures with at least one multiple-source benzodiazepine product.

Prior authorization will be granted for 12 months for documented:

- Generalized anxiety disorder.
- Panic attack with or without agoraphobia.
- Seizure.
- Nonprogressive motor disorder.
- Bipolar depression.
- Dystonia.

Prior authorization will be granted for three months for all other diagnoses related to the use of benzodiazepines.

### 14. Single-Source Nonsteroidal Anti-Inflammatory Drugs

Prior authorization is required for single-source nonsteroidal anti-inflammatory drugs unless the patient was established on a single-source nonsteroidal anti-inflammatory product before October 1, 1992. Prior authorization is *not* required for multiple-source nonsteroidal anti-inflammatory drugs.

Included in the definition of 'single-source' is the innovator of a multiple-source drug, or "brand name." Payment for a single-source nonsteroidal anti-inflammatory drug will be authorized only for cases in which there is documentation of previous trials and therapy failures with at least two multiple-source nonsteroidal anti-inflammatory drugs.

Once a prior authorization has been issued for the single-source nonsteroidal anti-inflammatory drug, the drug may be changed to another single-source product within the approved time period without a new request.

### 15. Topical Tretinoin Products

Prior authorization is required for all topical tretinoin products. Additional examination will occur when the request is for a patient over 15 years of age. Payment for topical tretinoin therapy will be authorized for the following diagnoses:

- Skin cancer.
- Lamellar ichthyosis.
- Darier's disease.

These diagnoses do not require previous trails and therapy failure with other legend or non-legend anti-acne products regardless of age. Approval will be granted for lifetime use.

Payment for topical tretinoin product therapy will be authorized for the diagnosis of preponderance of comedonal acne.

This diagnosis does *not* require previous trial and therapy failure with other legend or non-legend anti-acne products regardless of age. Approval will be granted for an initial three-month period. If topical tretinoin therapy is effective after the initial approval period, prior authorization will be granted for a one-year period.

**16. Selected Brand-Name Drugs**

Prior authorization is required for selected brand name drugs for which there is available an "A" rated bioequivalent generic product as determined by the federal Food and Drug Administration. The Department selects these from those brand name drugs recommended by the Iowa Medicaid Drug Utilization Review Commission after consultation with the state associations representing physicians.

For prior authorization to be considered, evidence of a treatment failure with the bioequivalent generic drug must be provided. A copy of a completed Med Watch form, FDA form 3500, as submitted to the federal Food and Drug Administration shall be considered as evidence of a treatment failure.

The comparable brand name products to the generic products on the following list require prior authorization.

Acetaminophen; Butalbital; Caffeine
- 325 mg; 50 mg; 40 mg, capsule, oral
- 325 mg; 50 mg; 40 mg, tablet, oral

Acetaminophen; Codeine Phosphate
- 300 mg; 15 mg, tablet, oral
- 300 mg; 30 mg, tablet, oral
- 300 mg; 60 mg, tablet, oral

Acetaminophen; Hydrocodone Bitartrate
- 500 mg; 5 mg, capsule, oral
- 500 mg; 5 mg, tablet, oral
- 500 mg; 7.5 mg, tablet, oral
- 750 mg; 7.5 mg, tablet, oral

Acetaminophen; Oxycodone Hydrochloride
- 500 mg; 5 mg, capsule, oral
- 325 mg; 5 mg, tablet, oral

Acetaminophen; Propoxyphene Hydrochloride
650 mg; 65 mg, tablet, oral

Acetaminophen; Propoxyphene Napsylate
650 mg; 100 mg, tablet, oral

Acetazolamide
125 mg, tablet, oral
250 mg, tablet, oral

Albuterol Sulfate
Eq. 2 mg base/5 ml, syrup, oral
Eq. 2 mg base, tablet, oral
Eq. 4 mg base, tablet, oral

Allopurinol
100 mg, tablet, oral
300 mg, tablet, oral

Amantadine Hydrochloride
100 mg, capsule, oral
50 mg/5 ml, syrup, oral

Amiloride Hydrochloride; Hydrochlorothiazide
Eq. 5 mg Anhydrous; 50 mg, tablet, oral

Amitriptyline Hydrochloride
10 mg, tablet, oral
25 mg, tablet, oral
50 mg, tablet, oral
75 mg, tablet, oral
100 mg, tablet, oral
150 mg, tablet, oral

Amitriptyline Hydrochloride; Chlordiazepoxide
Eq. 12.5 mg base; 5 mg, tablet, oral
Eq. 25 mg base; 10 mg, tablet, oral

Amitriptyline Hydrochloride; Perphenazine
10 mg; 2 mg, tablet, oral
10 mg; 4 mg, tablet, oral
25 mg; 2 mg, tablet, oral
25 mg; 4 mg, tablet, oral
50 mg; 4 mg, tablet, oral

Amoxapine
25 mg, tablet, oral
50 mg, tablet, oral
100 mg, tablet, oral
150 mg, tablet, oral

Aspirin; Butalbital; Caffeine
325 mg; 50 mg; 40 mg, capsule, oral
325 mg; 50 mg; 40 mg, tablet, oral

Aspirin; Caffeine; Propoxyphene Hydrochloride
389 mg; 32.4 mg; 65 mg, capsule, oral

Aspirin; Carisoprodol
325 mg; 200 mg, tablet, oral

Aspirin; Methocarbamol
325 mg; 400 mg, tablet, oral

Aspirin; Oxycodone Hydrochloride; Oxycodone Terephthalate
325 mg; 4.5 mg; 0.38, tablet, oral

Atenolol
25 mg, tablet, oral
50 mg, tablet, oral
100 mg, tablet, oral

Atenolol; chlorthalidone
50 mg; 25 mg, tablet, oral
100 mg; 25 mg, tablet, oral

Atropine Sulfate; Diphenoxylate Hydrochloride
0.025 mg; 2.5 mg, tablet, oral

Baclofen
10 mg, tablet, oral
20 mg, tablet, oral

Benzonatate
100 mg, capsule, oral

Benztropine Mesylate
0.5 mg, tablet, oral
1 mg, tablet, oral
2 mg, tablet, oral

Betamethasone Dipropionate
Eq. 0.05% base, cream, topical
Eq. 0.05% base, lotion, topical
Eq. 0.05% base, ointment, topical

Betamethasone Valerate
Eq. 0.1% base, cream, topical
Eq. 0.1% base, lotion, topical
Eq. 0.1% base, ointment, topical

Bethanechol Chloride
- 5 mg, tablet, oral
- 10 mg, tablet, oral
- 25 mg, tablet, oral
- 50 mg, tablet, oral

Butabarbital Sodium
- 30 mg/5 ml, elixir, oral

Carbidopa; Levodopa
- 10 mg; 100 mg, tablet, oral
- 25 mg; 100 mg, tablet, oral
- 25 mg; 250 mg, tablet, oral

Carisoprodol
- 350 mg, tablet, oral

Cephalexin
- Eq. 250 mg base, capsule, oral
- Eq. 500 mg base, capsule, oral
- Eq. 125 mg base/5 ml, powder for reconstitution, oral
- Eq. 250 mg base/5 ml, powder for reconstitution, oral
- Eq. 250 mg base, tablet, oral
- Eq. 500 mg base, tablet, oral

Cephradine
- 250 mg, capsule, oral
- 500 mg, capsule, oral
- 125 mg/5 ml, powder for reconstitution, oral
- 250 mg/5 ml, powder for reconstitution, oral

Chlorothiazide
- 250 mg, tablet, oral
- 500 mg, tablet, oral

Chlorpropamide
100 mg, tablet, oral
250 mg, tablet, oral

Chlorthalidone
25 mg, tablet, oral
50 mg, tablet, oral

Chlorthalidone; Clonidine Hydrochloride
15 mg; 0.1 mg, tablet, oral
15 mg; 0.2 mg, tablet, oral
15 mg; 0.3 mg, tablet, oral

Chlorzoxazone
250 mg, tablet, oral
500 mg, tablet, oral

Clemastine Fumarate
2.68 mg, tablet oral

Clindamycin Hydrochloride
Eq. 150 mg base, capsule, oral

Clofibrate
500 mg, capsule, oral

Clonidine Hydrochloride
0.1 mg, tablet, oral
0.2 mg, tablet, oral
0.3 mg, tablet, oral

Cloxacillin Sodium
Eq. 250 mg base, capsule, oral
Eq. 500 mg base, capsule, oral
Eq. 125 mg base/5 ml powder for reconstitution, oral

Cyclobenzaprine Hydrochloride
10 mg, tablet, oral

Cyproheptadine Hydrochloride
4 mg, tablet, oral

Desipramine Hydrochloride
25 mg, tablet, oral
50 mg, tablet, oral
75 mg, tablet, oral
100 mg, tablet, oral

Diltiazem Hydrochloride
60 mg, capsule, extended release, oral
90 mg, capsule, extended release, oral
30 mg, tablet, oral
60 mg, tablet, oral
90 mg, tablet, oral
120 mg, tablet, oral

Diphenhydramine Hydrochloride
25 mg, capsule, oral
50 mg, capsule, oral
12.5 mg/5 ml, elixir, oral

Disopyramide Phosphate
Eq. 100 mg base, capsule, oral
Eq. 150 mg base, capsule, oral

Doxepin Hydrochloride
Eq. 10 mg base, capsule, oral
Eq. 25 mg base, capsule, oral
Eq. 50 mg base, capsule, oral
Eq. 75 mg base, capsule, oral
Eq. 100 mg base, capsule, oral
Eq. 150 mg base, capsule, oral

Doxycycline Hyclate
- Eq. 100 mg base, capsule, oral
- Eq. 100 mg base, capsule, coated pellets, oral
- Eq. 100 mg base, tablet, oral

Ergoloid Mesylates
- 1 mg, tablet, oral
- 0.5 mg, tablet, sublingual
- 1 mg, tablet, sublingual

Ethinyl Estradiol; Norethindrone
- 0.035 mg; 0.5 mg, tablet, oral
- 0.035 mg; 1 mg, tablet, oral

Fluocinolone Acetonide
- 0.01%, cream, topical
- 0.025%, cream, topical
- 0.025%, ointment, topical
- 0.01%, solution, topical

Fluocinonide
- 0.05%, ointment, topical
- 0.05%, solution, topical
- 0.05%, cream, topical
- 0.05%, gel, topical

Fluphenazine Hydrochloride
- 1 mg, tablet, oral
- 2.5 mg, tablet, oral
- 5 mg, tablet, oral
- 10 mg, tablet, oral

Furosemide
- 20 mg, tablet, oral
- 40 mg, tablet, oral
- 80 mg, tablet, oral

Gemfibrozil
600 mg, tablet, oral

Haloperidol
0.5 mg, tablet, oral
1 mg, tablet, oral
2 mg, tablet, oral
5 mg, tablet, oral
10 mg, tablet, oral
20 mg, tablet, oral

Hydralazine Hydrochloride
10 mg, tablet, oral
25 mg, tablet, oral
50 mg, tablet, oral
100 mg, tablet, oral

Hydralazine Hydrochloride; Hydrochlorothiazide
25 mg; 25 mg, capsule, oral
50 mg; 50 mg, capsule, oral
100 mg; 50 mg, capsule, oral

Hydrochlorothiazide
25 mg, tablet, oral
50 mg, tablet, oral
100 mg, tablet, oral

Hydrochlorothiazide; Methyldopa
15 mg; 250 mg, tablet, oral
25 mg; 250 mg, tablet, oral
30 mg; 500 mg, tablet, oral
50 mg; 500 mg, tablet, oral

Hydrochlorothiazide, Propranolol Hydrochloride
25 mg; 40 mg, tablet, oral
25 mg; 80 mg, tablet, oral

Hydrochlorothiazide; Spironolactone
25 mg; 25 mg, tablet, oral

Hydrochlorothiazide; Triamterene
25 mg; 50 mg, capsule, oral
25 mg; 37.5 mg, tablet, oral
50 mg; 75 mg, tablet, oral

Hydroxyzine Hydrochloride
10 mg, tablet, oral
25 mg, tablet, oral
50 mg, tablet, oral

Hydroxyzine Pamoate
Eq. 25 mg hcl, capsule, oral
Eq. 50 mg hcl, capsule, oral
Eq. 100 mg hcl, capsule, oral

Imipramine Hydrochloride
10 mg, tablet, oral
25 mg, tablet, oral
50 mg, tablet, oral

Isosorbide Dinitrate
5 mg, tablet, oral
10 mg, tablet, oral
20 mg, tablet, oral
30 mg, tablet, oral
2.5 mg, tablet, sublingual
5 mg, tablet, sublingual

Lactulose
10 gm/15 ml, syrup, oral

Lindane
1%, lotion, topical
1%, shampoo, topical

Lithium Carbonate
300 mg, capsule, oral

Loxapine Succinate
Eq. 5 mg base, capsule, oral
Eq. 10 mg base, capsule, oral
Eq. 25 mg base, capsule, oral
Eq. 50 mg base, capsule, oral

Maprotiline Hydrochloride
25 mg, tablet, oral
50 mg, tablet, oral
75 mg, tablet, oral

Meclizine Hydrochloride
12.5 mg, tablet, oral
25 mg, tablet, oral
25 mg, tablet, chewable, oral

Megestrol Acetate
20 mg, tablet, oral
40 mg, tablet, oral

Meprobamate
200 mg, tablet, oral
400 mg, tablet, oral

Mestranol; Norethindrone
0.05 mg; 1 mg, tablet, oral

Metaproterenol Sulfate
- 10 mg/5 ml, syrup, oral
- 10 mg, tablet, oral
- 20 mg, tablet, oral

Methocarbamol
- 500 mg, tablet, oral
- 750 mg, tablet, oral

Methyclothiazide
- 2.5 mg, tablet, oral
- 5 mg, tablet, oral

Methyldopa
- 125 mg, tablet, oral
- 250 mg, tablet, oral
- 500 mg, tablet, oral

Metoclopramide Hydrochloride
- Eq. 5 mg base, tablet, oral
- Eq. 10 mg base, tablet, oral

Metoprolol Tartrate
- 50 mg, tablet, oral
- 100 mg, tablet, oral

Nifedipine
- 10 mg, capsule, oral
- 20 mg, capsule, oral

Nortriptyline Hydrochloride
- Eq. 10 mg base, capsule, oral
- Eq. 25 mg base, capsule, oral
- Eq. 50 mg base, capsule, oral
- Eq. 75 mg base, capsule, oral

Oxybutynin Chloride
5 mg, tablet, oral

Perphenazine
2 mg, tablet, oral
4 mg, tablet, oral
8 mg, tablet, oral
16 mg, tablet, oral

Pindolol
5 mg, tablet, oral
10 mg, tablet, oral

Potassium Chloride
8 meq, tablet, extended release, oral

Prazosin Hydrochloride
Eq. 1 mg base, capsule, oral
Eq. 2 mg base, capsule, oral
Eq. 5 mg base, capsule, oral

Prednisone
1 mg, tablet, oral
5 mg, tablet, oral
10 mg, tablet, oral
20 mg, tablet, oral
50 mg, tablet, oral

Primidone
250 mg, tablet, oral

Probenecid
500 mg, tablet, oral

Procainamide Hydrochloride
- 250 mg, capsule, oral
- 375 mg, capsule, oral
- 500 mg, capsule, oral
- 250 mg, tablet, extended release, oral
- 500 mg, tablet, extended release, oral
- 750 mg, tablet, extended release, oral

Propoxyphene Hydrochloride
- 65 mg, capsule, oral

Propranolol Hydrochloride
- 60 mg, capsule, extended release, oral
- 80 mg, capsule, extended release, oral
- 120 mg, capsule, extended release, oral
- 160 mg, capsule, extended release, oral
- 10 mg, tablet, oral
- 20 mg, tablet, oral
- 40 mg, tablet, oral
- 60 mg, tablet, oral
- 80 mg, tablet, oral
- 90 mg, tablet, oral

Selenium Sulfide
- 2.5%, lotion/shampoo, topical

Silver Sulfadiazine
- 1%, cream, topical

Spironolactone
- 25 mg, tablet, oral

Sulfamethoxazole; Trimethoprim
- 200 mg/5 ml; 40 mg/5 ml, suspension, oral
- 400 mg; 80 mg, tablet, oral
- 800 mg; 160 mg, tablet, oral

# C. Injected Medication

## 1. Covered Services

Payment will be approved for injections provided they are reasonable, necessary and related to the diagnosis and treatment of an illness or injury or are for purposes of immunization. The following information must be provided when billing for injections:

- Brand name of drug and manufacturer
- Strength of drug
- Amount administered
- Charge for each injection

When the strength and dosage information is not provided, claims will be denied. (This information is not needed if it is specified in the HCPC code.)

## 2. Noncovered or Limited Services

For injections related to diagnosis or treatment of illness or injury, the following specific exclusions are applicable:

- **Injections not indicated for treatment of a particular condition.** Payment will not be approved for injections when they are considered by standards of medical practice not to be specific or effective treatment for the particular condition for which they are administered.

  The Vitamin B-12 injection is an example. Medical practice generally calls for use of this injection when various physiological mechanisms produce a vitamin deficiency. Use of Vitamin B-12 in treating any unrelated condition will result in a disallowance.

- **Injections not for a particular illness.** Payment will not be approved for an injection if administered for a reason other than the treatment of a particular condition, illness or injury. **NOTE:** The physician must obtain prior approval before employing an amphetamine or legend vitamin by injection. (See Chapter F, Section I.)

- **Method of injection not indicated.** Payment will not be approved when injection is not an indicated method of administration according to accepted standards of medical practice.

- **Allergenic extract injection.** Claims from suppliers of allergenic extract materials provided the patient for self-administration will be allowed according to coverage limits in effect for this service.

- **Excessive injections.** Basic standards of medical practice provide guidance as to the frequency and duration of injections. These vary and depend upon the required level of care for a particular condition. The circumstances must be noted on the claim before additional payment can be approved.

  When excessive injections appear, representing a departure from accepted standards of medical practice, the entire charge for injections given in excess of these standards will be excluded. For example, such an action might occur when Vitamin B-12 injections are given for pernicious anemia more frequently than the accepted intervals.

  If an injection is determined to fall outside of what is medically reasonable or necessary, the entire charge (i.e., for both the drug and its administration) will be excluded from payment. Therefore, if a charge is made for an office visit primarily for the purpose of administering drugs, it will be disallowed along with the noncovered injections.

## D. Nonlegend Drugs

Payment for the following listed drugs will be made in the same manner as for prescription drugs, except that a maximum allowable cost (MAC) is established at the median of the average wholesale prices of the chemically equivalent products available. Current maximum allowable costs are listed below. No exceptions for reimbursement for higher cost products will be approved.

| | **MAC PER TABLET OR ML** |
|---|---|
| Acetaminophen tablets, 325 mg | $.0156 |
| Acetaminophen tablets, 500 mg | .0225 |
| Acetaminophen elixir, 120 mg/5 ml | .0039 |
| Acetaminophen elixir, 160 mg/5 ml | .0061 |
| Acetaminophen solution, 100 mg/ml | .1693 |
| Acetaminophen suppositories, 120 mg | .4575 |

| | |
|---|---|
| Aspirin, 81 mg | .0497 |
| Aspirin tablets, 325 mg | .0099 |
| Aspirin tablets, 650 mg | .0287 |
| Aspirin tablets, enteric-coated, 325 mg | .0197 |
| Aspirin tablets, enteric-coated, 650 mg | .0263 |
| Aspirin tablets, buffered, 325 mg | .0170 |
| Bacitracin ointment, 500 units/GM | .0880 |
| Benzoyl peroxide 5% gel | .0422 |
| Benzoyl peroxide 5% lotion | .0537 |
| Benzoyl peroxide 5% wash | .0632 |
| Benzoyl peroxide 10% gel | .0440 |
| Benzoyl peroxide 10% lotion | .0550 |
| Benzoyl peroxide 10% wash | .0676 |
| Chlorpheniramine maleate, tablets, 4 mg | .0103 |
| Ferrous sulfate tablets, 300 mg | .0147 |
| Ferrous sulfate tablets, 325 mg | .0147 |
| Ferrous sulfate elixir, 220 mg/5 ml | .0050 |
| Ferrous sulfate drops, 75 mg/0.6 ml | .0388 |
| Ferrous gluconate tablets, 320 mg | .0159 |
| Ferrous gluconate tablets, 325 mg | .0149 |
| Ferrous gluconate elixir, 300 mg/5 ml | .0138 |
| Ferrous fumarate tablets, 300 mg | .0152 |
| Ferrous fumarate tablets, 325 mg | .0159 |
| Niacin 50 mg tablets | .0175 |
| Niacin 100 mg tablets | .0195 |
| Niacin 250 mg tablets | .0360 |
| Niacin 500 mg tablets | .0284 |
| Pediatric oral electrolyte solutions | .0054 |
| Permethrin liquid | .1363 |
| Pseudoephedrine syrup 30 mg/5 ml | .0200 |
| Pseudoephedrine tablets 30 mg | .0210 |
| Pseudoephedrine tablets 60 mg | .0410 |
| Sodium chloride solution 0.9% for inhalation with metered dispensing value | .0451 |
| Tolnaftate 1% cream | .1167 |
| Tolnaftate 1% powder | .0700 |
| Tolnaftate 1% solution | .2290 |

Nonprescription multiple vitamin and mineral products are payable when specifically formulated and recommended for use as a dietary supplement during pregnancy and lactation.

With prior authorization, nonprescription multiple vitamins and minerals are also payable under conditions specified under III. B. **Drugs Requiring Prior Approval of the Fiscal Agent**.

Oral solid forms of these items shall be prescribed and dispensed in a minimum quantity of 100 units per prescription, except when dispensed via a unit-dose system. When used for maintenance therapy, all of these items may be prescribed and dispensed in 90-day quantities.

## E. Cost and Quantity Standards

### 1. General Policies

Physicians are requested to cooperate with the Department in keeping the cost of drugs to a minimum, consistent with a good quality of patient care.

When a medication is available at several price levels, prescribe low-cost items whenever possible. In writing prescriptions, prescribe a 30-day supply, unless therapeutically contraindicated.

Exception: Maintenance drugs in the following classifications may be prescribed in 90-day quantities for use in prolonged therapy:

- Oral contraceptives
- Cardiac drugs (cardiotonic glycosides, digitalis, antiarrhythmic drugs)
- Hypotensive agents (captopril, enalapril, diltiazem, etc.)
- Vasodilating agents (diphenylhydatoin, primidone, phenobarbital (as anticonvulsant only), etc.)
- Diuretics
- Anticoagulants
- Thyroid and antithyroid agents
- Antidiabetic agents

**2. Unit-Dose Packaging**

Additional reimbursement of one cent per dose, added to the ingredient cost, is available for dispensing oral solids to nursing home patients in unit-dose packages prepared by the pharmacist.

**NOTE:** Payment may be made only for unit-dose-package drugs which are consumed by the patient. Any previous charges for intact unit-dose packages returned to the pharmacy must be credited to the program. Such credits may be shown on future billings. If no additional billings are to be made, direct a refund in the appropriate amount to the fiscal agent. (Only refund of the drug cost component is required.)

**3. Basis of Payment for Drugs**

*Maximum allowable cost* (MAC) is defined as the upper limit for multiple-source drugs established in accordance with the methodology of the Health Care Financing Administration, as described in 42 CFR 447.332(a)(i) and (ii).

The basis of payment for prescribed drugs for which the MAC has been established and for Schedule II controlled drugs is the lesser of the submitted acquisition cost or the MAC, plus a professional dispensing fee which is the lower of:

- The customary fee to the general public,
- The seventy fifth percentile of customary fees charged in Iowa, or
- A fee of $4.02.

The basis of payment for other drugs is the lesser of the submitted acquisition cost or the estimated acquisition cost (the average wholesale price as published by First Data Bank less ten percent), plus a professional dispensing fee which is the lower of:

- The customary fee to the general public,
- The seventy-fifth percentile of fees charged in Iowa, or
- A fee of $6.25.

If you certify in your own handwriting that, in your medical judgment, a specific brand is medically necessary for a particular patient, the MAC does not apply and the payment equals the average wholesale price of the brand name

produce less 10 percent. If you do not so certify, and the pharmacist does not substitute a lower cost equivalent product, the payment for the product equals the established MAC.

An example of an acceptable certification is the notation "brand necessary." A procedure for checking a box on a form does not constitute an acceptable certification. The notations "Do not substitute" and "Dispense as written" are not acceptable certification, nor is a blanket letter covering all prescriptions.

Equivalent products are defined as those products which meet therapeutic equivalence standards as published in the federal Food and Drug Administration document *Approved Prescription Drug Products with Therapeutic Equivalence Evaluations*.

## F. Noncovered Drugs

Payment will not be made for:

- Drugs classified as less than effective by the Food and Drug Administration.
- Over-the-counter products not listed in Section III, Part D.
- Multiple vitamins or tonic preparations and combinations of these with minerals, hormones, stimulants, or other compounds which are available as separate entities for treatment of specific conditions, such as Beroca, Sigtabs, and Theragran Hematinic.
- Smoking cessation products.
- Drugs used as anorexiants or for weight gain.
- Drugs used for cosmetic purposes or for hair growth.
- Drugs prescribed for a use which is not a medically accepted indication, as defined by Section 1927(K)(6) of the Social Security Act. The term "medically accepted indication" means any use for a covered outpatient drug which is approved under the Federal Food, Drug, and Cosmetic Act, which appears in peer-reviewed medical literature, or which is accepted by one or more of the following compendia:
  - American Hospital Formulary Service-Drug Information
  - American Medical Association Drug Evaluations

- United States Pharmacopeia-Drug Information
- Drugs used for fertility purposes

# IV. HOSPITAL CARE

Payment will be made for inpatient hospital care as medically necessary. There are no specific limits on the number of days of inpatient care for which Medicaid payment will be approved, as long as that care is medically necessary in the individual case.

If the IFMC determines the care is not medically necessary, the patient, physician, or hospital can request a reconsideration of the decision by filing a written request for reconsideration with IFMC within 365 days from the date of the hospital's remittance notice. The aggrieved party can appeal a denial by IFMC of a request for reconsideration to the Department.

No waiver days will be allowed.

## A. PRO Review for Inpatient Hospital Care

The Iowa Foundation for Medical Care (IFMC), the PRO in Iowa, will randomly select a sample of inpatient hospital claims from Iowa and bordering hospitals. Claims will be reviewed for the appropriateness of admission, readmission, transfer, discharge, DRG assignment, coding, invasive procedures and quality of care. The IFMC will also profile claim data, review results and identify DRGs and procedures that may be targeted for retrospective review.

## B. Review of Specific Admissions

Admissions to physical rehabilitation units and swing bed/lower level of care require preadmission and continued stay review by the PRO.

From previous profiling of claims, admissions in the targeted areas will be reviewed retrospectively. These admissions include:

- Pediatric pneumonia and asthma
- Obstetrical admissions which do not result in a delivery
- Other focused review for specific DRGs

These admissions do not require approval before admission, but a sample of the admissions are reviewed retrospectively. Review will be selected or intensified based on review results and quarterly profiling of claims data.

### C. Outpatient Procedure List

The Iowa Foundation for Medical Care (IFMC) routinely makes available the *Outpatient Procedure List* which reflects procedures that can usually be performed safely on an outpatient basis when they are routine and primary procedures. Medicaid adopts the IFMC listing for procedures that should be performed in the outpatient setting.

### D. Use of Emergency Room

Payment will be approved for a fee for use of an emergency room providing at least one of the following conditions is met:

- The patient is evaluated or treated for a medical emergency, accident, or injury.
- The patient's evaluation or treatment results in a utilization review committee approval for inpatient hospital admission.
- The patient is referred by a physician.
- The patient is suffering from an acute allergic reaction.
- The patient is experiencing acute, severe respiratory distress.

## V. SURGERY

### A. Same-Day Surgery

Payment will not be made for inpatient hospital care for certain surgical procedures which can ordinarily be performed safely and effectively in the hospital outpatient department, physician's office, or other setting. Exceptions will be made when the admitting physician presents information to the hospital utilization review liaison justifying the medical necessity for inpatient care in the individual case.

Level of care designations for specific procedure are identified in the IFMC *Invasive Procedure Criteria*. The criteria are available from local hospital utilization review offices or from the IFMC.

In the absence of justifying information, claims for inpatient care for the procedures will be denied. The reviews for necessity are part of the retrospective hospital review process.

If the IFMC concurs that inpatient care is necessary, then payment for the care will be approved. If you do not present adequate justifying information before admitting of the patient, or, for an emergency admission, if the hospital record does not justify the necessity of inpatient care, *then payment of both the hospital claim for inpatient care and your claim for the surgery will be denied*.

## B. Surgical Assistance

Payment will be made for each surgical assistant fee. For multiple surgical assists for the same patient in the same operating session, payment will be made with the multiple surgery methodology (100%, 50%, 25%, 25%, etc.).

For a physician, the surgical code must be billed using an -80 modifier (payment is 16 percent of the surgical fee). For a physician assistant, the surgical code must be billed using an -AS modifier (payment is 65 percent of the physician surgical assist fee). The assistant at surgery claim must be submitted on a separate claim form from the primary surgeon's bill.

## C. Preprocedure Surgical Review

To ensure that surgical procedures are medically necessary, the IFMC conducts a preprocedure review for the Medicaid program. The IFMC reviews selected high-frequency procedures when they are performed on an inpatient basis, in the outpatient unit of a hospital, or in a free-standing surgical unit.

**Note:** Recipients enrolled in Managed Health Care require preprocedure review for transplant procedures and obesity surgeries only.

## 1. Requirements

The decision to approve or deny payment for the procedure is based on the information provided to the IFMC. The IFMC needs the following information for preprocedure and preadmission review:

- Procedure
- Proposed admission date
- Hospital or location of intended procedure
- Patient's name and address
- Patient's age
- Patient's Medicaid ID number
- Attending or surgical physician's name
- Tentative diagnosis
- Orders
- History and chief complaint (include symptoms and duration of problem)
- Other medical history or problem
- Preadmission treatment
- Outpatient studies performed
- Medication

See and evaluate the patient before the IFMC is contacted for preprocedure certification. Complete information should be available at that time. Payment will be denied for lack of complete information if the patient has not been evaluated.

The review must be conducted no earlier than six weeks before the procedure in order to review the most accurate information. **Exception:** Heart transplant, bone marrow transplant, liver transplant, lung transplant, and obesity surgery requests may be made earlier than six weeks before the procedure.

**2. Process**

To obtain a review, contact the IFMC by phone at 800/373-2964. Telephone review is available from the IFMC during normal working hours Monday through Friday.

**Exception:** Make requests for obesity surgery, heart transplants, bone marrow transplants, and liver transplants to the IFMC *in writing*. Send the information needed to complete the review to:

Iowa Foundation for Medical Care
6000 Westown Parkway, Suite 350E
West Des Moines, Iowa 50266-7771

IFMC acute care review staff conduct the reviews. The staff is experienced in preprocedure review as well as in utilization and quality review.

Physicians have established criteria to be used by the nurse reviewer for each of the selected procedures. These criteria are available from IFMC or in local hospital utilization review offices.

The IFMC will grant approval only if the procedures are determined to be necessary, based on review and coverage guidelines of the IFMC and the Department. If the procedure is approved, the coordinator will notify you or your representative.

All approved preprocedure reviews are given validation numbers at the time of review. In addition, the IFMC will check the computerized claims information on all denied procedures to ensure that no denied procedure is covered under Medicaid payment.

You are responsible for notifying the patient of the decision and for notifying the hospital, the ambulatory surgical center, and other involved physicians of the assigned validation number, since this must be entered on claim forms. The nine-digit validation number assigned by the IFMC must be entered in the appropriate block of the HCFA-1500 claim form or UB-92 claim form.

### 3. Denials

Questionable cases are referred to a physician reviewer for a medical review determination. Whenever possible, physicians who perform the procedure being reviewed are used for peer review decisions.

If the physician reviewer determines the procedure is not medically necessary, IFMC issues a preprocedure denial letter to the patient, physician, hospital, and fiscal agent.

If IFMC does not approve the procedure, Medicaid payment will not be made to the physician or to the facility in which the surgery is performed. Presumptive waiver does not apply. A reconsideration is available to all involved parties by filing a written request with the IFMC within 365 days from the date of remittance.

A denial determination following a request for reconsideration by the IFMC can be appealed to the Department by the aggrieved party.

## D. Procedure List for Preprocedure Review

The following is a list of the surgical procedures that are subject to preprocedure review. Major categories are indicated. Surgical procedures falling under those categories for which approval must be obtained are listed with their CPT-4 and ICD-9-CM codes.

| | | |
|---|---|---|
| Bone marrow transplant | 38240 | 41.00 |
| | 38241 | 41.01 |
| | | 41.02 |
| | | 41.03 |
| Heart transplant | 33945 | 37.5 |
| Liver transplant auxiliary | 47135 | 50.51 |
| Other transplant of liver | 47135 | 50.59 |
| Lung transplant | 32851 | 33.50 |
| Unilateral lung transplant | 32852 | 33.51 |
| Bilateral lung transplant | 32853 | 33.52 |
| | 32854 | |
| High gastric bypass | 43847 | 44.31 |
| (Printen and Mason) | 43846 | |
| Gastric stapling (gastroplasty) | 43326 | 44.69 |
| | 43842 | |
| | 43843 | |
| | 43848 | |
| Small bowel bypass | 43846 | 45.91 |

Requests for review of these elective procedures must be in writing and must be submitted to: IFMC, 6000 Westown Parkway, Suite 350E, West Des Moines, Iowa 50266-7771.

## E. Preoperative and Postoperative Visits

The reimbursement fees for all major surgeries include four preoperative days. Any visits performed by the surgeon or co-surgeon within four days before a major surgery are included in the surgical fee reimbursement and are not separately payable.

Major surgical fees also include postoperative days. Depending on the surgery, the postoperative days range from 5 days to 14 days.

**Exception:** Endoscopic procedure reimbursement does not include preoperative and postoperative visits.

## F. Cosmetic Surgery

### 1. Coverage

Cosmetic surgery or expenses incurred in connection with such surgery are not covered under the Medicaid program, except when required for the prompt (i.e., as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member.

For Medicaid purposes, “cosmetic” reconstructive or plastic surgery is surgery which can be expected primarily to improve physical appearance, which is performed primarily for psychological purposes, or which restores form, but which does not correct or materially improve the bodily functions.

When a surgical procedure primarily restores bodily function, whether or not there is also a concomitant improvement in physical appearance, the surgical procedure does not fall within the provisions of this policy. Surgeries for the purpose of sex reassignment are not considered as restoring bodily function and are excluded from coverage.

Medicaid coverage is generally not available for cosmetic reconstructive or plastic surgery. However, payment for otherwise covered services and supplies may be provided in connection with reconstructive or plastic surgery for:

- Correction of a congenital anomaly.
- Restoration of body form following an accidental injury.
- Revision of disfiguring and extensive scars resulting from neoplastic surgery.

Generally, coverage is limited to those cosmetic reconstructive or plastic surgery procedures provided no later than 12 months after the related accidental injury or surgical trauma. However, special consideration or exception will be given to cases involving children who may require a growth period.

**2. Excluded Services**

Cosmetic reconstructive or plastic surgery performed in connection with certain conditions is specifically excluded. These conditions are:

- Dental congenital anomalies, such as absent tooth buds, malocclusion, and similar conditions.
- Procedures related to transsexualism, hermaphroditism, gender identity disorders, or body dysmorphic disorders.
- Cosmetic reconstructive or plastic surgery procedures performed primarily for psychological reasons or as a result of the aging process.
- Breast augmentation mammoplasty, surgical insertion of prosthetic testicles, penile implant procedures, and surgeries for the purpose of sex reassignment.
- Any procedure performed for personal reasons, to improve the appearance of an obvious feature or part of the body which would be considered by an average observer to be normal and acceptable for the patient's age or ethnic or racial background.

- Cosmetic, reconstructive, or plastic surgery procedures which are justified primarily on the basis of a psychological or psychiatric need.
- Face lifts and other procedures related to the aging process.
- Reduction mammoplasties, unless there is medical documentation of intractable pain not amendable to other forms of treatment as the result of increasingly large pendulous breasts.
- Panniculectomy and body sculpture procedures, unless there is medical documentation of chronic infection or other complication.
- Repair of sagging eyelids, unless there is demonstrated and medically documented significant impairment of vision.
- Rhinoplasties, unless there is evidence of accidental injury occurring within the past six months which resulted in significant obstruction of breathing.
- Chemical peeling for facial wrinkles.
- Dermabrasion of the face.
- Revision of scars resulting from surgery or a disease process, except disfiguring and extensive scars resulting from neoplastic surgery.
- Removal of tattoos.
- Hair transplants.
- Electrolysis.
- Sex reassignment.

When it is determined that a cosmetic reconstructive or plastic surgery procedure does not qualify for Medicaid coverage, all related services and supplies, including institutional costs, are also excluded.

Coverage is available for otherwise covered services and supplies required in the treatment of complications resulting from a noncovered incident of treatment, but only when the subsequent complications represent a separate medical condition, such as systemic infection, cardiac arrest, acute drug reaction, or similar conditions.

Coverage shall not be extended for any subsequent care or procedure related to the complication that is essentially similar to the initial noncovered care. Examples of complications similar to the initial care are repair of facial scarring resulting from dermabrasion for acne or repair of a prolapsed vagina in a biological male who has undergone transsexual surgery.

## G. Abortions

Iowa law restricts Medicaid abortion payment to the following situations:

- The attending physician certifies in writing based on professional judgment that the fetus is physically deformed, mentally deficient, or afflicted with a congenital illness and states the medical indications for determining the fetal condition.
- The attending physician certifies in writing based on professional judgment that the pregnant woman's life would be endangered if the fetus was carried to term.
- An official of a law enforcement agency or public or private health agency (which may include a family physician), certifies in writing that:
  - The pregnancy is the result of rape that was reported to the agency within 45 days of the date of the incident, and
  - The report contains the name, address, and signature of the person making it.
- An official of a law enforcement agency or public or private health agency (which may include a family physician) certifies in writing that:
  - The pregnancy resulted from incest that was reported to the agency within 150 days of the incident, and
  - The report contains the name, address, and signature of the person making it.
- Treatment is required for a spontaneous abortion or miscarriage where all the products of conception are not expelled.

Federal funding is available to terminate a pregnancy that was the result of rape or incest. Federal funding is also available if the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed.

All abortion claims must be billed with the appropriate ICD-9 abortion diagnosis and CPT abortion procedure code on the HCFA 1500 claim. A copy of form 470-0836, *Certification Regarding Abortion*, must be attached to the physician's claim. (See Item 4 in this section for a facsimile of the form and further instructions.)

Documentation in addition to form 470-0836 identifying the reason for the abortion must be attached to the claim. This includes:

- The operative report.
- The pathology report.
- Laboratory reports.
- The ultrasound report.
- Physician progress notes.
- Other documents that support the diagnosis.

**1. Coverage of Mifepristone (Mifeprex or RU-486)**

Mifepristone, when used in combination with misprostol, is used to terminate a pregnancy. All of the previous federal and state criteria for coverage of abortions apply to the use of Mifepristone (Mifeprex or RU-486). This includes the coverage criteria, form 470-0836 and medical records.

The following codes are available for billing abortions:

| | |
|---|---|
| S0190 | Mifepristone, oral, 200 MG |
| S0191 | Misoprostol, oral, 200 MCG |
| S0199 | Medically induced abortion by oral ingestion of medication including all associated services and supplies (e.g., patient counseling, office visits, confirmation of pregnancy by HCG, ultrasound to confirm duration of pregnancy, ultrasound to confirm completion of abortion) except drugs. |

The Medicaid program considers S0199 a 'global' code. The fee is set to cover all of the services identified in the description. Only codes S0190 and S0191 are to be billed in addition to this code. Bill these procedure codes on the HCFA 1500 with the required certification form and medical records.

**2. Covered Services Associated With Noncovered Abortions**

The following services are covered even if performed in connection with an abortion that is not covered:

- Services that would have been performed on a pregnant woman regardless of whether she was seeking an abortion, including:
  - Pregnancy tests.
  - Tests to identify sexually transmitted diseases (e.g., chlamydia, gonorrhea, syphilis).
  - Laboratory tests routinely performed on a pregnant patient, such as pap smear and urinalysis, hemoglobin, hematocrit, rubella titre, hepatitis B, and blood typing.
- Charges for all services, tests and procedures performed post abortion for complications of a non-covered therapeutic abortion, including charges for:
  - Services following a septic abortion.
  - A hospital stay beyond the normal length of stay for abortions.

**Note:** Family planning or sterilization must not be billed on the same claim with an abortion service. Bill these services separately from the abortion claim.

### 3. Noncovered Services

The following abortion related services are not allowed when the abortion is not covered by federal or state criteria:

- Physician and surgical charges for performing the abortion. These charges include the usual, uncomplicated pre- and post-operative care and visits related to performing the abortion.
- Hospital or clinic charges associated with the abortion. This includes the facility fee for use of the operating room; supplies and drugs necessary to perform the abortion, and charges associated with routine, uncomplicated pre- and post-operative visits by the patient.
- Physician charges for administering the anesthesia necessary to induce or perform an abortion.
- Drug charges for medication usually provided to or prescribed for the patient who undergoes an uncomplicated abortion. This includes routinely provided oral analgesics and antibiotics to prevent septic complications of abortion and Rho-GAM (an immune globulin administered to Rh negative women who have an abortion).
- Charges for other laboratory tests performed before performing the non-covered abortion to determine the anesthetic or surgical risk of the patient (e.g., CBC, electrolytes, blood typing).
- Charges for histo-pathological tests performed routinely on the extracted fetus or abortion contents.
- Uterine ultrasounds performed immediately following an abortion.

### 4. Certification Regarding Abortion, 470-0836

Payment cannot be made either to the attending physician, to other physicians assisting in the abortion, to the anesthetist, or to the hospital or ambulatory surgical center if the required certification is not submitted with the claim for payment.

It is the responsibility of the physician to make a copy of form 470-0836, *Certification Regarding Abortion*, available to the hospital, other physicians, CRNAs, anesthetists, or ambulatory surgical centers billing for the service. This will facilitate payment to the hospital and other physicians on abortion claims.

In case of a pregnancy resulting from rape or incest, a certification from a law enforcement agency, public or private health agency, or family physician is required as noted above. It is the responsibility of the recipient, someone acting in her behalf, or the attending physician to obtain the necessary certification from the agency involved. Form 470-0836 is also to be used for this purpose.

See the following pages for a facsimile of form 470-0836.

Iowa Department of Human Services

# CERTIFICATION REGARDING ABORTION

**I. CERTIFICATION BY PHYSICIAN**

**CERTIFY TO ONE OF THE FOLLOWING:**

I certify that on the basis of my professional judgment:

❑ **Life of the Mother (Federal Funding).** _____ suffers from
(Name and address of the mother)
a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself, that would place her in danger of death unless an abortion is performed.

❑ **Life of the Mother (State Funding).** The life of _____
(Name and address of the mother)
would be endangered if the fetus were carried to term.

❑ **Fetus Deformed.** The fetus carried by _____
(Name and address of the mother)
is physically deformed, mentally deficient, or afflicted with a congenital illness based on: _____

_____

_____
(Medical indications)

_____ MD/DO (Signature) _____ Date _____

---

**II. CERTIFICATION BY AGENCY**

**1. Rape**

I, _____, of _____ received
(Name of Official) (Name of Agency)
a signed form from _____
(Name and address of person reporting)
stating that _____ was the victim of an incident of rape.
(Name and address of the mother)
The incident took place on _____ and the incident was reported on _____
(Date) (Date)
The report included the name, address and signature of the person making the report.

_____ Date _____
(Signature of official of law enforcement, public or private health agency which may include a family physician)

**2. Incest**

I, _____, of _____ received
(Name of Official) (Name of Agency)
a signed form from _____
(Name and address of person reporting)
stating that _____ was the victim of an incest incident.
(Name and address of the mother)
The incident took place on _____ and the incident was reported on _____
(Date) (Date)
The report included the name, address and signature of the person making the report.

_____ Date _____
(Signature of official of law enforcement, public or private health agency which may include a family physician)

# CONDITIONS FOR MEDICAID PAYMENT FOR ABORTIONS

Legislation enacted by the Iowa General Assembly restricts payment for abortions through the Medicaid program to the following situations:

1. Where the attending physician certifies in writing that continuing the pregnancy would endanger the life of the pregnant woman. Federal funding is only available in these situations if the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed.

2. Where the attending physician certifies in writing on the basis of his/her professional judgment that the fetus is physically deformed, mentally deficient or afflicted with a congenital illness and states the medical indications for determining the fetal condition.

3. If the pregnancy is the result of rape, and that incident was reported to a law enforcement agency or public or private health agency, which may include a family physician, within 45 days of the date of the incident, and that report contains the name, address and signature of the person making the report. An official of the agency must so certify in writing.

4. If the pregnancy is the result of incest and that incident was reported to a law enforcement agency or public or private health agency, which may include a family physician, within 150 days of the incident, and that report contains the name, address and signature of the person making the report. An official of the agency or physician must so certify in writing.

A copy of the form, *Certification Regarding Abortion* (470-0836), must be attached to any Medicaid claim associated with the abortion. **Payment will not be made to the attending physician or to other physicians assisting in the abortion or to the hospital if the required certification is not submitted by the provider with the claim for payment.** It is the responsibility of the attending physician to make a copy of the certification available to the hospital and other physicians billing for the services associated with the abortion.

In the case of pregnancy resulting from rape or incest, a certification from a law enforcement agency, public or private health agency, or family physician is required as set forth above. The recipient, someone acting in her behalf, or the attending physician is responsible for obtaining the necessary certification from the agency involved. The form, *Certification Regarding Abortion* (470-0836), is to be used for this purpose. It is also the responsibility of the physician to make a copy of the certification available to the hospital and any other physician billing for the service. This will facilitate payment to the hospitals and other physicians on abortion claims.

## H. Sterilizations

"Sterilization" means any medical procedure, treatment, or operation for the purpose of rendering a person incapable of reproducing, which is not a necessary part of the treatment of an existing illness or medically indicated as an accompaniment to an operation of the genitourinary tract. For purpose of this definition, mental illness or retardation is not considered an illness or injury.

Payment shall not be made through the Medicaid Program for sterilization of a person who is under 21 at the time of consent or who is legally mentally incompetent or institutionalized.

A "legally mentally incompetent person" is a person who has been declared mentally incompetent by a federal, state, or local court for any purpose, unless the court declares the person competent for purposes which include the ability to consent to sterilization.

An "institutionalized person" is a person who is involuntarily confined or detained under a civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or confined under voluntary commitment in a mental hospital or facility for the care and treatment of mental illness.

Please note: Reversal of sterilization is not a covered Medicaid service.

### 1. Conditions

Medicaid payment may be made for the sterilization of a person when the following conditions are met:

- The person to be sterilized must voluntarily request the service.
- A knowledgeable informant must give the person to be sterilized an explanation of the procedures to be performed, upon which the person can base the consent for sterilization.

- An "informed consent" is required. The person must be age 21 or over when the consent form is signed. The person must be mentally competent and noninstitutionalized in accordance with the above definitions.
- The person to be sterilized must be advised that the person is free to withhold or withdraw consent to the procedure at any time before the sterilization without prejudicing future care or loss of other program benefits to which the person might otherwise be entitled.

**2. Informed Consent**

"Informed consent" means the voluntary knowing assent from the person to be sterilized; after the person has been given a complete explanation of what is involved and has signed a written document to that effect.

The "informed consent" shall be obtained on form 470-0835 or 470-0835S, *Consent Form*. If the person is blind, deaf, or does not understand the language used to provide the explanation, an interpreter must be provided. The person may be accompanied by a witness of the person's choice.

The informed consent shall not be obtained while the person is in labor or childbirth, seeking to obtain or obtaining an abortion, or under the influence of alcohol or other substance that affects the person's state of awareness. The elements of explanation which must be provided are:

- A thorough explanation of the procedures to be followed and the benefits to be expected.
- A description of the attendant discomforts and risks, including the possible effects of the anesthetic to be used.
- Counseling concerning appropriate alternative methods of family planning and the effect and impact of the proposed sterilization, including the fact that it must be considered to be an irreversible procedure. (Reversal of sterilization is not a covered Medicaid service.)
- An offer to answer any inquires concerning the proposed procedures.

### 3. Time Frame

The "informed consent" must be obtained at least 30 days but not more than 180 days before the sterilization is performed, except when emergency abdominal surgery or premature delivery occurs. When emergency abdominal surgery occurs, at least 72 hours must have elapsed after the consent form was obtained for the exception to be approved. When a premature delivery occurs, at least 72 hours must have elapsed after the informed consent was obtained, and the documentation must also indicate that the expected delivery date was at least 30 days after the informed consent was signed for the exception to be approved. The patient must be 21 years of age or older at the time of consent.

### 4. Consent Form, 470-0835 and 470-0835S

The physician's copy of the *Consent Form*, 470-0835 or 470-0835S, must be completely executed in all aspects according to the above directions and attached to the claim in order to receive payment. No substitute form is accepted. A claim for physician's services for sterilization may be denied, due to either failure to have the consent form signed at least 30 days but not more than 180 days before service is provided or failure to use the official *Consent Form*, 470-0835 or 470-0835S. If so, any claim submitted by the hospital, anesthesiologists, assistant surgeon or associated providers for the same procedure will also be denied. The hospital and other providers associated with the sterilization services must obtain a photocopy of the complete consent form, and attach it to their claim when submitted to the fiscal agent for payment.

All names, signatures and dates on the *Consent Form*, 470-0835 or 470-0835S, must be fully, accurately and legibly completed. The only exceptions to this

requirement are that the "Interpreter's Statement " is completed only if an interpreter is actually provided to assist the patient to be sterilized. Also, the information requested pertaining to race and ethnicity may be supplied voluntarily on the part of the patient, but is not required.

It is the responsibility of the person obtaining the consent form to verify that the patient requesting the sterilization is at least 21 years of age on the date that the patient signs the form. If there is any question pertaining to the true age of the patient, the birth date must be verified.

The "Statement of Person Obtaining Consent" may be completed by any qualified professional capable of clearly explaining all aspects of sterilization and alternate methods of birth control which are available to the patient.

The "Physician's Statement" must be completed fully and signed by the PHYSICIAN PERFORMING THE STERILIZATION and dated when signed. One of the paragraphs at the bottom of this statement must be crossed out. Be sure to cross out the paragraph that does not apply to the situation. If paragraph two is appropriate, indicate the expected date of delivery and circumstances involving emergency abdominal surgery.

Since the physician performing the sterilization will be the last person to sign the consent form, the physician should provide a photocopy of the fully completed consent form to every other Medicaid provider involved in the sterilization that will submit a claim, e.g., hospital, anesthetist, assistant surgeon, etc. The only signatures which should be on the completed consent form are those of the patient, the interpreter, if interpretation services were provided, the person obtaining the consent and the physician performing the sterilization.

A supply of the form may be obtained from the fiscal agent on request.

**5. Facsimile Consent Form, 470-0835 and 470-0835S**

Iowa Department of Human Services

# CONSENT FOR STERILIZATION

***NOTICE:*** *Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving federal funds.*

## CONSENT TO STERILIZATION

I have asked for and received information about sterilization from _____. When I first asked for the
*doctor or clinic*
information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving federal funds, such as FIP or Medicaid that I am now getting or for which I may become eligible.

I understand that the sterilization must be considered **permanent** and **not reversible**. I have decided that I do not want to become pregnant, bear children or father children.

I was told about temporary methods of birth control that are available and could be provided to me that would allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____.

The discomforts, risks, and benefits with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least 30 days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on _____ _____ _____.
*month* *day* *year*

I _____,
hereby consent of my own free will to be sterilized by
_____, by a method called
*doctor*
_____.

My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health and Human Services or
- Employees of programs or projects funded by that Department ,

but only for the purpose of determining if federal laws were observed.

I have received a copy of this form.

| Signature | Month Day Year |
|---|---|
| | |

*The following race and ethnicity information is requested, but is not required:*
Race and ethnicity designation (*please check*):

- ❑ White (not of Hispanic origin)
- ❑ Black (not of Hispanic origin)
- ❑ Hispanic
- ❑ Asian or Pacific Islander
- ❑ American Indian or Alaska Native

## INTERPRETER'S STATEMENT

*If an interpreter is provided to assist the person to be sterilized:*

I have translated the information and advice presented orally to the person to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief, he/she understood this explanation.

| Interpreter | Date |
|---|---|
| | |

## STATEMENT OF PERSON OBTAINING CONSENT

Before _____ signed the
*name of person*
consent form, I explained to him/her the nature of the sterilization operation, _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks, and benefits associated with it.

I counseled the person to be sterilized that alternative methods of birth control are available that are temporary. I explained that sterilization is different because it is permanent.

I informed the person to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by federal funds.

To the best of my knowledge and belief, the person to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

| Signature of person obtaining consent | Date |
|---|---|
| | |
| Facility | |
| | |
| Address | |
| | |

## PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon _____
_____ on _____
*name of person to be sterilized* *date of sterilization operation*
I explained to him/her the nature of the sterilization operation
_____, the fact that it is intended to be a
*specify type of operation*
final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the person to be sterilized that alternative methods of birth control are available that are temporary. I explained that sterilization is different because it is permanent.

I informed the person to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by federal funds.

To the best of my knowledge and belief, the person to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure.

*(**Instructions for use of alternative final paragraphs:** Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the person's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)*

(1) At least 30 days have passed between the date of the person's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the person's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ❑ Premature delivery; person's expected date of delivery _____
- ❑ Emergency abdominal surgery: (describe circumstances): _____

| Physician | Date |
|---|---|
| | |

# FORMULARIO DE CONSENTIMIENTO REQUERIDO

***NOTA:*** *Si en cualquier momento decide no hacerse esterilizar ello no resultara en que se le retiren o retengan cualquiera de los beneficios proporcionados por programas o proyectos que reciben fondos del gobierno federal.*

## CONSENTIMIENTO PARA LA ESTERILIZACIÓN

He pedido y recibido informacion sobre la esterilización de _____. Cuando me informé al respecto,
*(doctor o clinica)*
se me dijo que la decisión de hacerme esterilizar es absolutamente mía. Me han informado que, si así lo deseo, puedo decidir no hacerme esterilizar. Si decido no hacerme esterilizar, esta decisión no afectará mis derechos a cuidados o tratamiento futuros. No perderé ninguno de los beneficios de programas que reciben fondos federales, como por ejemplo FIP o Medicaid que esté recibiendo en la actualidad o que pueda recibir en el futuro.

Entiendo que la esterilización se considera **permanente e irrevocable**. He decidido que no quiero quedar embarazada, tener hijos o procrear hijos.

Se me ha informado acerca de los métodos anticonceptivos que están disponibles y que se me podrán proporcionar, los que sí me permitirán tener un hijo o procrear un hijo en el futuro. He rechazado estas alternativas y he elegido el ser esterilizado(a).

Entiendo que seré esterilizado(a) por medio de una operación conocida bajo el nombre de _____. Los inconvenientes, riesgos y beneficios asociados con esta operación me han sido explicados. Todas mis preguntas han sido contestadas en forma satisfactoria.

Entiendo que la operación no se hará hasta por lo menos 30 días después de haber firmado este consentimiento. Entiendo que puedo cambiar de opinión en cualquier momento y que mi decisión de no hacerme esterilizar no resultará en que se me retiren cualquiera de los beneficios o servicios médicos proporcionados por fondos federales.

Tengo por lo menos 21 anõs de edad y naci el _____ _____ _____.
*mes* *día* *año*

Yo, _____,
por la presente consiento por mi propia voluntad a que me esterilice _____, por el método conocido como
*(doctor)*
_____.
Mi consentimiento se vence a los 180 días de la fecha de mi firma.

También consiento a que este formulario y otros antecedentes médicos sean puestos a la disposición de:

- Representantes del Departamento de Salud, Educación y Bienestar (Department of Health, Education and Welfare) o
- Empleados de programas o proyectos que operan con fondos de ese departamento, pero solamente para determinar si se han cumplido las leyes federales.

He recibido una copia de este formulario.

| *firma* | *mes día año* |
|---|---|
| | |

Se le pide que proporcione la siguiente información, pero esto no es obligatorio:

*Raza y Designación Etnica (haga una marca):*

❑ Negro (no de orígen hispano)
❑ Hispano
❑ Asiático o de Islas del Pacifico
❑ Indio Norteamericano o Nativo de Alaska
❑ Blanco (no de orígen hispano)

## DECLARACION DEL INTERPRETE

Si se proporciona un intérprete para asistir a la persona a ser esterilizada:

He traducido la información y consejos incluídos dados en forma oral por la persona que obtiene este consentimiento, a la persona a ser esterilizada. También le he leído el formulario de consentimiento en el idioma _____ y le he explicado su contenido. Según mi mejor entender esta persona ha comprendido esta explicación.

| *intérprete* | *fecha* |
|---|---|
| | |

## DECLARACION DE LA PERSONA QUE OBTIENE ESTE CONSENTIMIENTO

Antes de que _____ firmara este
*nombre de la persona*
formulario de consentimiento, le he explicado la naturaleza de la operación para la esterilización llamada _____, y el hecho de que se trata de un procedimiento final e irrevocable, habiéndole explicado también los inconvenientes, riesgos y beneficios que la acompañan.

Advertí a la persona a ser esterilizada que existen métodos anticonceptivos alternos, que son temporarios. Le expliqué que la esterilización es diferente porque es permanente.

He informado a la persona a ser esterilizada que puede retirar su consentimiento en cualquier momento y que no perderá ninguno de los servicios de salud o cualquier otro beneficio proporcionado con fondos federales.

De acuerdo a mi mejor entender, la persona a ser esterilizada tiene por lo menos 21 años de edad y parece tener capacidad mental suficiente. Esta persona ha solicitado en forma voluntaria, con pleno conocimiento de lo que implica, que la esterilicen y parece comprender la naturaleza y consecuencias del procedimiento.

| *firma de la persona que obtiene el consentimiento* | *fecha* |
|---|---|
| *establecimiento* | |
| *dirección* | |

## DECLARACION DEL MEDICO

Poco antes de efectuar la operación para la esterilización de _____ el _____
*nombre de la persona a ser esterilizada* *fecha de la operación*
le expliqué la naturaleza de la operación llamada _____
*tipo de operación*
así como el hecho de que es un procedimiento final e irrevocable, así como los inconvenientes, riesgos y beneficios derivados del mismo.

He advertido a la persona a ser esterilizada que existen métodos anticonceptivos que son temporarios. Le he explicado que la esterilización es diferente, porque es permanente.

He informado a la persona a ser esterilizada que su consentimiento puede ser retirado en cualquier momento y que por ello no perdera ninguno de los cuidados médicos o beneficios proporcionados por fondos federales.

A mi mejor entender, la persona a ser esterilizada tiene por lo menos 21 años de edad y tiene la suficiente capacidad mental. Ha pedido voluntariamente y con pleno conocimiento el ser esterilizado(a) y parece comprender la naturaleza y consecuencias del procedimiento.

(**Instruccciones para el uso de párrafos finales alternos:** Utilice el primer párrafo que sigue, excepto en casos de parto prematuro o cirugía abdominal de emergencia, en que la esterilización se efectúa menos de 30 días despúes de la fecha de la firma del formulario de consentimiento. En dichos casos, deberá usarse el segundo párrafo de los que siguen. Tache el párrafo que no utilice.)

(1) Por lo menos treinta días han transcurrido entre la fecha en que la persona firmó el formulario de consentimiento y la fecha en que se efectuó la operación de esterilización.

(2) Esta esterilización fue efectuada menos de 30 días pero mas de 72 horas después de haber firmado la persona el formulario de consentimiento, debido a las circunstancias siguientes (haga una marca donde corresponda y de la información requerida):

❑ Parto prematuro
Fecha en que debiera haber ocurrido el parto: _____

❑ Cirugía abdominal de emergencia: (describa las circunstancias)

_____

| *médico* | *fecha* |
|---|---|
| | |

### 6. Hysterectomies

Payment will be made for a medically necessary hysterectomy only when it is performed for a purpose other than sterilization, and only when one or more of the following conditions are met:

a. The patient or representative has signed an acknowledgment that she has been informed orally and in writing that the hysterectomy will make the patient permanently incapable of reproducing. The vehicle for transmitting the acknowledge that the patient received the explanation before the surgery should not be the *Consent Form,* 470-0835 or 470-0835S.

The statement must be signed by the patient or representative and must be submitted with the claim for Medicaid payment. The following language is satisfactory for such a statement:

> *"Before the surgery, I received a complete explanation of the effects of this surgery, including the fact that it will result in sterilization.*
>
> *(Date) (Signature of Patient or Person Acting on Her Behalf)"*

This statement may be added to either the surgery consent form, the claim form, or on a separate sheet of paper, so that the statement can be submitted to the fiscal agent with the related claims.

b. The patient was already sterile before the hysterectomy. The physician must certify in writing that the patient was already sterile at the time of the hysterectomy and has stated the cause of the sterility. The following language is satisfactory for such a statement:

> *"Before the surgery, this patient was sterile and the cause of that sterility was* _____.
>
> *(Physician's Signature) (Date)"*

This statement may be added to either the surgery consent form, the claim form, or on a separate sheet of paper, so that the statement is submitted to the fiscal agent with the related claims.

Any statement or documentation stating the cause of sterility must be signed and dated by a physician. This includes history and physical, operative reports, or claim forms.

c. The hysterectomy was performed as the result of a life-threatening emergency situation in which the physician determined that prior acknowledgment was not possible, and the physician includes a description of the nature of the emergency.

If the physician certifies that the hysterectomy was performed in a life-threatening emergency and includes a description of the nature of the emergency, the claim will be reviewed on an individual basis and will be permitted only in extreme emergencies.

Where the patient is about to undergo abdominal exploratory surgery or a biopsy, and removal of the uterus is a potential consequence of the surgery, the patient should be informed of this possibility and given an opportunity to acknowledge in writing the receipt of this information.

Copies of the statement or documentation required above to determine the medical necessity of the hysterectomy shall be made available for every other Medicaid provider involved that will submit a claim, e.g., hospital, anesthetist, assistant surgeon.

## I. Organ Transplants

Payment will be made only for the following organ and tissue transplant services when medically necessary:

1. Kidney, cornea, and skin transplants.

2. Allogeneic bone marrow transplants for the treatment of leukemia, aplastic anemia, severe combined immunodeficiency disease (SCID), Wiskott-Aldrich syndrome.

3. Autologous bone marrow transplants for treatment of the following conditions: acute leukemia in remission with a high probability of relapse when there is no matched donor, resistant non-Hodgkin's lymphomas, lymphomas presenting poor prognostic features, recurrent or refractory neuroblastoma, or advanced Hodgkin's disease when conventional therapy has failed and there is no matched donor.

4. Liver transplants for persons with extrahepatic biliary atresia or any other form of end-state liver disease, except that coverage is not provided for persons with a malignancy extending beyond the margins of the liver or those with persistent viremia. Liver transplants require preprocedure review by the Iowa Foundation for Medical Care and are payable only when performed in a facility which meets the requirements set forth by the Department.

5. Heart transplants. Heart transplants require preprocedure review by the Iowa Foundation for Medical Care and are payable only when performed in a facility which meets the requirements set forth by the Department.

   Artificial hearts and ventricular assist devices are not covered, either as a permanent replacement for a human heart or as a temporary life-support system until a human heart becomes available for transplants.

6. Lung transplants for persons with end stage pulmonary disease. Lung transplants require preprocedure review by the Iowa Foundation for Medical Care and are payable only in a lung transplant facility certified by Medicare.

Donor expenses incurred directly in connection with a covered transplant are payable. Expenses incurred for complications that arise with respect to the donor are covered only if they are directly and immediately attributed to surgery. Expenses of searching for a donor are not covered.

# VI. RELATED SERVICES

## A. Transportation to Receive Medical Care

To help ensure that Medicaid recipients have access to medical care within the scope of the program, the Department reimburses recipients under certain conditions for transportation to receive necessary medical care.

Except for "Care for Kids" services, payment is limited to situations when it is necessary for the recipient to travel outside the community to receive needed medical care or, when the recipient lives in a rural area, to travel to the nearest community to receive care.

Under the EPSDT "Care for Kids" program, local transportation is available for screening, diagnosis, or treatment. If a recipient is in need of this service, contact the designated DPH agency for assistance. See the appendix for list of designated agencies.

Payment in all situations is limited to the nearest source of adequate and appropriate care. The recipient is reimbursed only for the distance to the nearest doctor, dentist, etc., who can provide the necessary service.

This policy is not intended to limit the recipient's free choice of practitioner. However, because of limited funds in the Medicaid program, payment can be made for transportation only to the nearest source of necessary care.

If you refer a Medicaid recipient to a specialist or a hospital in another community, the same policy applies. The recipient will be reimbursed by the Department only for the distance to the nearest available specialist or hospital, unless you indicate that, in view of the diagnosis and condition of the recipient, a more distant specialist or hospital is the only appropriate source of care.

When there is a nearer specialist of the same type or a nearer hospital, the county office may contact you to verify the necessity of referral to the more distant physician or hospital, in order to document the necessity of reimbursing the recipient for the greater distance.

## B. Ambulance Services

Payment will be approved through the Medicaid program for ambulance service, providing the use of any other method of transportation is medically contraindicated by the patient's condition. The patient must be transported to the nearest hospital with appropriate facilities, from one hospital to another, or to a skilled nursing facility or licensed nursing home.

If the patient is initially transferred to one hospital with appropriate facilities but later taken to another hospital in the same locality, payment for the second trip will be approved only if there is a valid reason for transporting the patient (as opposed to a patient's personal preference). An example would be where the patient requires inpatient hospital services which were not available at the first hospital.

### 1. Noncovered Services

Payment will not be approved for the following:

a. Transportation of a patient from home or a nursing home to a physician's office or clinic (free-standing or hospital-based), or back, unless the transportation is required for specialized treatment available at the location.

b. Transportation of a patient from home or a nursing home to the outpatient department of a hospital, unless the trip was an emergency or otherwise medically necessary.

c. Transportation from one private home to another.

d. Transportation of a patient to University Hospitals at Iowa City, unless the University Hospitals is the nearest hospital with facilities necessary to the care of the patient.

e. Transportation to obtain the services of a specific physician. Reference: Medicare Part B, Intermediary Manual, Section 2130.3C.

**2. Medical Necessity**

The Medical Review Unit in the office of the fiscal agent is responsible for determining the ambulance service was medically necessary and that the condition of the patient precluded any other method of transportation.

a. Cases not requiring confirmation of physician. The fiscal agent can generally pay claims without confirmation from the physician or the medical facility when:

(1) The recipient is admitted as a hospital inpatient.

(2) In an emergency situation, such as a result of an accident, injury or acute illness.

(3) Information submitted with the claim clearly indicates that ambulance service was necessary, showing diagnosis and treatment of the condition which gave rise to the need for ambulance service. The fiscal agent relies on information from the physician and hospital to determine if the patient's condition requires ambulance transportation; therefore, all claims related to treatment provided in connection with ambulance transportation should contain sufficient information about the patient's diagnosis and medical condition to substantiate the need for ambulance services.

b. Cases requiring confirmation of physician. The fiscal agent cannot presume medical necessity for ambulance service in the following cases:

(1) The patient is ambulatory;

(2) The patient is not admitted as a hospital inpatient (except in accident cases);

(3) The patient has been transported regularly by ambulance to the hospital outpatient department for continuing treatment and is regularly returned home;

(4) The patient was transported by ambulance between the hospital outpatient department and a nursing home where the patient was living.

In these and similar cases the fiscal agent may find it necessary to request information from the ambulance company (who may in turn request it from the physician) to determine medical necessity and whether payment of a claim should be approved or denied.

We request your assistance in supplying the information, when requested, to determine if ambulance service can be covered by Medicaid.

## C. Enhanced Services for High-Risk Pregnant Women

Enhanced services shall be provided to supplement the prenatal care of high-risk pregnant women. Enhanced services are currently provided only by the following providers: maternal health centers, rural health centers, and federally qualified health centers. Enhanced services furnished by these providers include care coordination, health education, social services, nutrition education, and a postpartum home visit.

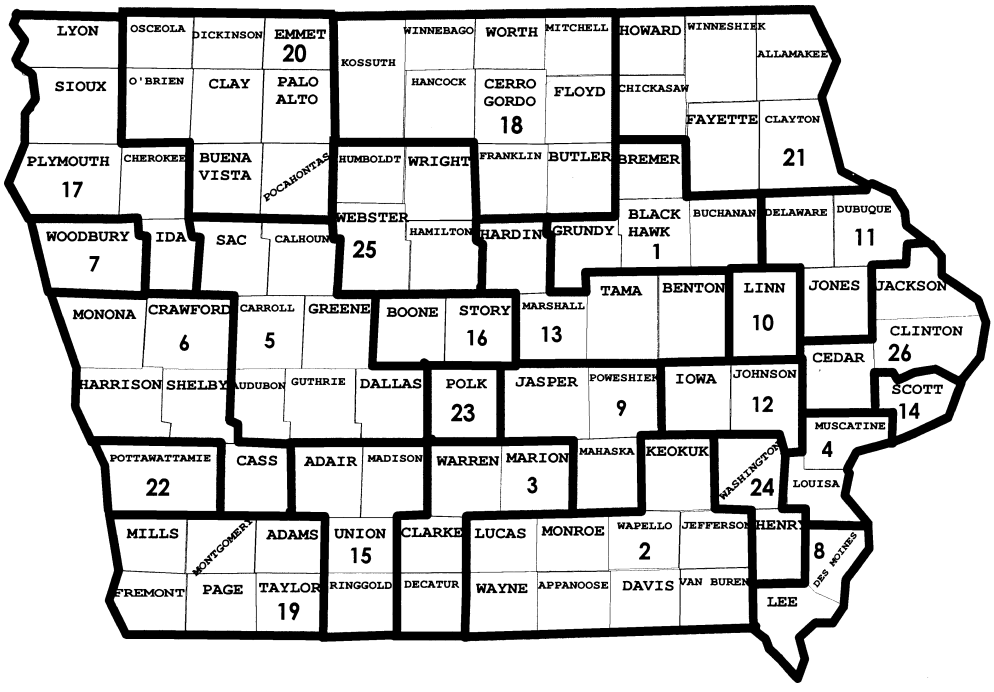
Enhanced prenatal services may be provided by licensed dietitians, bachelor-degreed social workers, physicians, and registered nurses. A physician (from one of the above-listed providers) must be involved in staffing the patient's receiving enhanced services. Trimester and postpartum reports shall be provided to the referring physician.

- A registered nurse or social worker shall coordinate comprehensive prenatal service by:
  - An individual plan of care based on client needs including pregnancy, personal, and interpersonal issues. This includes counseling (coaching, supporting, educating, listing, encouraging, feedback, etc.), referral, and assistance for other specified services such as mental health.
  - Ensuring that the client receives all components as appropriate (medical, education, nutrition, psychosocial, and postpartum home visit).
  - Tracking risk.
- A registered nurse shall provide education services including, as appropriate, education about high-risk medical conditions: high-risk sexual behavior, smoking cessation, alcohol usage, drug usage, and environmental and occupational hazards.
- A licensed dietitian shall provide nutrition assessment and counseling which includes:
  - Initial assessment of nutritional risk based on height, current and prepregnancy weight status, laboratory data, clinical data, and self-reported dietary information.
  - Ongoing nutritional assessment.
  - Development of an individualized nutritional care plan.
  - Referral to food assistance programs, if indicated.
  - Nutritional intervention.
- A social worker shall provide psychosocial assessment and counseling which includes:
  - A psychosocial assessment including needs assessment, a profile of client demographic factors, mental and physical health history and concerns, adjustment to pregnancy and future parenting, and environmental needs.
  - A profile of the client's family composition, patterns of functioning, and support system.
  - An assessment-based plan of care, risk tracking, counseling and anticipatory guidance as appropriate, and referral and follow-up services.

- A registered nurse shall provide a home visit within two weeks of the child's discharge from the hospital, which includes;
  - Assessment of mother's health status.
  - Physical and emotional changes postpartum.
  - Family planning.
  - Parenting skills.
  - Assessment of infant health.
  - Infant care.
  - Grief support for unhealthy outcome.
  - Parenting a sick or preterm infant.
  - Identification and referral to community resources.

**1. Maternal Health Services Funded by the Iowa Department of Public Health**

Maternal health centers are one of the providers of enhanced services. The following pages list the maternal health centers in Iowa, their locations, and their service areas.



## LOCATION OF MATERNAL HEALTH CENTERS

1. **ALLEN MEMORIAL HOSPITAL**
   Women's Health Center
   233 Vold Drive
   Waterloo IA 50703
   (319) 235-5090

2. **AMERICAN HOME FINDING ASSOCIATION**
   Family Health Center
   317 Vanness Avenue
   Ottumwa IA 52501
   (515) 682-8784 / 800-452-1098

3. **COMMUNITY HEALTH SERVICES OF MARION COUNTY**
   104 South Sixth Street, P.O. Box 152
   Knoxville IA 50138
   (515) 828-2238

4. **UNITY HEALTH SYSTEM**
   1609 Cedar Street, 2nd Floor
   Muscatine IA 52761
   (563) 263-0122

5. **COMMUNITY OPPORTUNITIES, INC.**
   603 W. 8th Street
   Carroll IA 51401
   (712) 792-9266 / 800-642-6330

6. **CRAWFORD COUNTY HOME HEALTH AND HOSPICE**
   105 N. Main (Courthouse Annex)
   Denison IA 51442
   (712) 263-2314

7. **CRITTENTON CENTER**
   2417 Pierce Street, P.O. Box 295
   Sioux City IA 51102-0295
   (712) 255-4321

8. **DES MOINES COUNTY HEALTH DEPARTMENT**
   522 North 3rd Street
   Burlington IA 52601
   (319) 753-8215

9. **GRINNELL REGIONAL MEDICAL CENTER**
   210 - 4th Avenue
   Grinnell IA 50112
   (515) 236-2273

10. **HAWKEYE AREA COMMUNITY ACTION PROGRAM, INC.**
    5560 - 6th Street, SW
    Cedar Rapids IA 52404
    (319) 366-7875

11. **HILLCREST FAMILY SERVICES**
    Hillcrest-Mercy Maternal Health Clinic
    102 Professional Arts, Mercy Drive
    Dubuque IA 52001
    (563) 589-8595

12. **JOHNSON COUNTY DEPARTMENT OF PUBLIC HEALTH**
    1105 Gilbert Court
    Iowa City IA 52240
    (319) 356-6045

13. **LEE COUNTY HEALTH DEPARTMENT**
    2218 Avenue H, Suite A
    Fort Madison IA 52627
    (319) 372-5225

14. **MATURA ACTION CORPORATION**
    203 W. Adams Street
    Creston IA 50801
    (515) 782-8431

15. **MID-IOWA COMMUNITY ACTION, INC.**
    1001 South 18th Avenue
    Marshalltown IA 50158
    (515) 752-7162
    Story Co.: (515) 292-1944

16. **MID-SIOUX OPPORTUNITY, INC.**
    418 Marion Street
    Remsen IA 51050
    (712) 786-2001 / 800-859-2025

17. **NORTH IOWA COMMUNITY ACTION ORGANIZATION**
    300 - 15th Street NE, P.O. Box 1627
    Mason City IA 50401
    (515) 423-5044 / 800-657-5856

18. **SCOTT COUNTY HEALTH DEPARTMENT**
    428 Western Avenue, 5th Floor
    Davenport IA 52801
    (563) 326-8618

19. **TAYLOR COUNTY PUBLIC HEALTH**
MCH Center of Southwest Iowa
405 Jefferson
Bedford IA 50833
(712) 523-3405

20. **UPPER DES MOINES OPPORTUNITY, INC.**
101 Robbins Avenue, P.O. Box 519
Graettinger IA 51342
(712) 859-3885

21. **FINLEY TRI-STATES HEALTH GROUP, INC./VISITING NURSE ASSOCIATION**
1454 Iowa Street
P.O. Box 359
Dubuque IA 52004
(563) 556-6200

22. **VNA OF POTTAWATTAMIE COUNTY**
300 West Broadway, Suite 10
Council Bluffs IA 51503
(712) 328-2636

23. **VISITING NURSE SERVICES**
1111 9th Street
Des Moines IA 50314
(515) 288-1516

24. **WASHINGTON COUNTY PHN SERVICE**
314 McCreedy Drive
Washington IA 52363
(319) 653-7758

25. **WEBSTER COUNTY PUBLIC HEALTH**
330 - 1st Avenue, North
Fort Dodge IA 50501
(515) 573-4107

26. **WOMEN'S HEALTH SERVICES**
215 - 6th Avenue South
Clinton IA 52732
(563) 243-1413

## 2. Obstetrical Care for Women Determined to be at High Risk

Additional reimbursement will be provided for obstetrical care provided to a woman who is determined to be at high risk by the *Medicaid Prenatal Risk Assessment*, form 470-2942.

Bill the appropriate CPT code and high-risk code in order to receive additional reimbursement. Submit a copy of form 470-2942 with paper claims. Providers using EMC Submissions may be requested to provide a copy of the form retrospectively. See VIII. E. **Obstetrical Services**, for billing instructions.

## D. Home Health Agency Services

Payment will be made for all services provided by a Medicare-certified home health agency on the written order of a physician. There is no requirement for a prior hospitalization, nor does the patient have to be homebound to be eligible for care.

Payment is limited to services which are "intermittent," as defined by Medicare. Services must be medically necessary.

Supplies are limited to $15 when provided by a home health agency. Supplies in excess of $15 for home health care can be accessed through a durable medical equipment provider.

Payment will be made both for restorative service as in the Medicare program and also for maintenance service. Essentially, maintenance service means service to a patient whose condition is stabilized and requires observation by a nurse of conditions defined by the physician as indicating a possible deterioration of health status.

Private duty nursing and personal care services are covered for patients age 20 and under. The services must be medically necessary, and receive prior authorization, and exceed intermittent limits.

## E. Services of Physical Therapists in Independent Practice

Payment will be approved for services rendered by a physical therapist subject to the conditions in effect in the Medicare program for restorative physical therapy. Medicare provides coverage for the services of a physical therapist in independent practice when furnished in the therapist's office or the patient's home. The physical therapist must meet licensing and other standards for participation n Medicare to qualify as a participating independently practicing physical therapist in the Medicaid program.

## F. Private-Duty Nurses

No payment will be made for services of a private-duty nurse, except under EPSDT home health agency services. (See Item D.)

# VII. BASIS OF PAYMENT FOR PHYSICIAN SERVICES

## A. Payment for Home Health Agency Services

For home health agency services, use the procedure codes and nomenclatures as shown in the most recent edition of *Current Procedural Terminology*, with CPT modifier when applicable. Additional two-letter HCPCS modifiers are found in Section VIII, **PROCEDURE CODES AND NOMENCLATURE**.

The Department has established a fee schedule with advice and consultation from the Iowa Medical Society and the Iowa Osteopathic Medical Association. Physicians will be reimbursed the lower level of customary charges and the fee schedule amount.

For selected medical services, supplies and equipment, which in the judgment of the Secretary of the Department of Health and Human Services generally do not vary significantly in quality from one provider to another, the upper limits for payments are the lowest charges for which such devices are widely and consistently available in a locality

For services and items also furnished under Part B of Medicare and for services and items furnished only under Medicaid, the upper limits are the lowest charges determined by the fiscal agent according to the Medicare reimbursement method. The Part B Medicare intermediary will advise physicians of the services and supplies so designated by the Secretary.

## B. Payment for Anesthesiologist Services

Anesthesia services coded (ASA codes) 00100 through 01999 and the anesthesia codes converted to W0950 through W0958 (noted under **Miscellaneous Services** later in the chapter) are reimbursed by multiplying the sum of the base units (assigned to the ASA code converted to minutes) and the time (in minutes) used in providing the anesthesia by a Medicaid reimbursement conversion factor.

Intrathecal narcotic for labor and delivery, code Z2850, is reimbursed from a fee schedule.

The American Society of Anesthesiologists states that "...anesthesia time begins when the anesthesiologist begins to prepare the patient for the induction of anesthesia in the operating room or in an equivalent area and ends when the anesthesiologist is no longer in personal attendance; that is, when the patient may be safely placed under post-operative supervision." Indicate time as the number of minutes.

Placement of an arterial line or a central venous pressure catheter is reimbursed separately from the anesthesia services provided when the base unit for the ASA code is less than 20 units (300 base minutes when converted from units to minutes). If the base unit for the ASA code is 20 (300 base minutes) or greater, the anesthesia preparation reimbursement includes placement of an arterial line or central venous pressure catheter.

Services of CRNAs employed by a physician can be billed either by the employing physician or by the CRNA, if enrolled as a Medicaid provider.

For CRNAs enrolled as Medicaid providers, instructions for billing and described in the CRNA provider manual. The CRNA's reimbursement can be paid to the employing physician even though the CRNA has a separate provider number. Such an arrangement can be made through the provider enrollment section of the fiscal agent.

To bill for CRNAs you employ, use the following modifiers:

- Use the modifier "ND" when the CRNA provides anesthesia with no medical direction from an anesthesiologist.
- Use the modifier "AB" when the CRNA provides anesthesia with medical direction from an anesthesiologist.

When the physician provides anesthesia, use the modifier "AA."

**Note:** "Medical direction" is defined as an anesthesiologist providing medical direction from the operating suite. A physician who is not an anesthesiologist (for example, a surgeon, urologist, family practice physician, etc.) is not eligible to receive reimbursement for medical direction of anesthesia.

## C. Payment for Continuous Epidural Analgesia

All physician specialties providing continuous epidural analgesia are reimbursed on a flat fee basis using CPT code 62279 (continuous injection of analgesic substance, diagnostic or therapeutic; epidural, lumbar, or caudal). Use this code both for pain management and for maternity-related anesthesia.

There is no reimbursement of anesthesia codes (base units plus time) for continuous epidural analgesia. The claim form must show one unit. Only one physician will be reimbursed for the continuous epidural analgesia procedure.

For maternity-related anesthesia, the delivery physician may bill for the epidural only if the physician administers the anesthesia from the beginning of the delivery to the end. If the delivering physician introduces the epidural catheter and then calls in an anesthesiologist to complete the anesthesia, only the anesthesiologist may bill for the epidural.

Management of the epidural analgesia after the placement of the continuous epidural analgesia line is included in the reimbursement.

If a physician anticipated a vaginal delivery and begins continuous epidural analgesia, but subsequently a Cesarean section becomes necessary, requiring general anesthesia, the physician may bill 62279, but must use the modifier 52 (reduced services). The anesthesiologist may bill for general anesthesia services provided.

If the anesthesiologist begins continuous epidural analgesia and subsequently, a Cesarean section becomes necessary requiring general anesthesia, the anesthesiologist may bill 62279 with the modifier 22 (unusual services). This will cause the claim to be reviewed for additional reimbursement. An explanation of the circumstances must be given when modifier 22 is used.

## D. Payment for Obstetrical Services

### 1. Global Obstetrical Care for Vaginal Deliveries

Global obstetrical care for vaginal deliveries is billed on one claim form using one code to reflect **total obstetrical care**. The date of delivery is the service date. DO NOT USE "from-to" dates. Units are "1." Claims for global services cannot be billed before the date of delivery.

Use CPT code 59400 for total obstetrical care, including antepartum care, vaginal delivery, postpartum care, and episiotomy. Reimbursement for this code includes all routine antepartum care, including urinalysis testing. No extra allowance is made for delivery of twins except in unusual circumstances with supporting documentation.

Code Z2850, intrathecal narcotic for labor and delivery, is payable separate from other obstetrical codes.

Additional services are allowed for complications during the pregnancy that involve care over and above normal antepartum care. The primary diagnosis must reflect the reason for the additional services. Radiology and nonroutine laboratory procedures may be billed in addition to the charge made for total obstetrical care.

Only one physician may submit a charge for obstetrical delivery. Antepartum care, postpartum care, and delivery must be billed as one global charge when provided by one clinic, even though different staff members may have been involved in the patient's care.

**2. Antepartum Care Only**

Evaluation and management CPT codes may be billed when only 1 - 3 antepartum care visits are provided **and** when delivery will not also be billed, e.g., when another physician or clinic will be doing the delivery, when the pregnancy is terminated, or when the patient is not eligible at the time of the delivery. The reason for billing antepartum care must be stated on the claim form, e.g., "Delivered by another physician." This statement cannot be used if the other physician is in the same clinic.

When evaluation and management codes are appropriate to bill antepartum care, use of the modifier "OB" shall accompany the evaluation and management CPT code. Use of the "OB" modifier affords increased reimbursement.

Postpayment reviews of evaluation and management CPT codes will be conducted to ensure the billing of appropriate levels of services. Routine obstetrical visits with no complications typically are at the level of CPT code 99212. When higher levels of evaluation and management codes are used, the physician's records must document the reasons a higher code was used.

CPT codes 59425 and 59426 may be billed when delivery will not also be billed, e.g., when another physician or clinic will be doing the delivery, when the pregnancy is terminated, or when the patient is not eligible at the time of the delivery. The reason for billing antepartum care must be stated on the claim form, e.g., "Delivered by another physician." This statement cannot be used if the other physician is in the same clinic.

**3. Postpartum Care Only**

Postpartum care only, code 59430, may be billed in the same circumstances as antepartum care, when the delivery is not being billed. The claim must state that delivery is not being billed.

**4. Cesarean Section Deliveries**

The same guidelines apply to Cesarean sections as apply to total obstetrical care. When you provide antepartum care and Cesarean delivery services, use the procedure code that includes antepartum care. When you have provided global care, do not use evaluation and management CPT codes for antepartum care. For example, code 59510 must be used for a Cesarean delivery when antepartum and postpartum care have also been provided.

Only one physician may submit a charge for obstetrical delivery. If a Cesarean section is required and the attending doctor is the assistant, show modifier "80" after the CPT code for Cesarean section including antepartum care. Use of the 80 modifier provides reimbursement for global obstetrical services and assistant surgeon services.

## E. Payment for Family Planning Services

Direct family planning services receive additional federal funds. Therefore, it is important to indicate family planning services on the claim form by adding modifier "Z2" after the procedure code.

Family planning services include the following:

- Examination and tests which are necessary before prescribing family planning services. (Please indicate in the description of the service if it is related to family planning.)
- Contraceptive services. (Sterilization procedures must meet the informed consent requirements as outlined in this manual.)
- Supplies for family planning, including such items as an IUD, a diaphragm, or a basal thermometer.

Services performed for abortions, childbirth, or the treatment of an illness or injury which have a secondary family planning relationship are not considered as family planning services. Do not mark these claims as family-planning-related.

Reversals of sterilization procedures are not covered procedures.

An implantable contraceptive capsule, such as NORPLANT, is billed as follows:

| | |
|---|---|
| 11975 | Insertion, implantable contraceptive capsules * (includes the cost of the product) |
| 11976 | Removal, implantable contraceptive capsules * |
| 11977 | Removal, with re-insertion, implantable contraceptive capsules * |
| W0207 | Inpatient/outpatient insertion of implantable contraceptive capsules * |

* Do not bill an office visit in addition to these codes.

## F. Payment for Osteopathic Manipulation Therapy

Medicaid recognizes five levels of procedure codes for osteopathic manipulation therapy, as described in the HCFA Common Procedure Coding System. (See Section VIII, **PROCEDURE CODES AND NOMENCLATURE**.) Claims using these codes must include a diagnosis directly relating to a musculoskeletal disorder.

An evaluation and management service may be billed in addition to the osteopathic manipulation therapy when an evaluation and management services is also provided. Use the "25" modifier with the evaluation and management code.

## G. Payment for Treatment of Chronic Renal Disease

Payment will be made on the same basis as Medicare for services associated with treatment of chronic renal disease. This includes physician's services, hospital care, renal transplantation, and hemodialysis, whether performed on an inpatient or outpatient basis.

Some patients under age 65 are eligible for Medicare if they need treatment for chronic renal disease. If these persons are also eligible for Medicaid, Medicaid payment will be made for Medicare deductibles and coinsurance.

# VIII. PROCEDURE CODES AND NOMENCLATURE

Claims submitted without a procedure code and appropriate ICD-9-CM diagnosis code will be denied.

Iowa uses the HCFA Common Procedure Coding System (HCPCS). HCPCS codes divided into three levels. Level 1 is the current CPT-4 codes. Level 2 codes are specifically designed regional five-digit codes beginning with letters A through V. Level 3 codes are specifically designed local codes beginning with letters W through Z. (Most of the local codes have been replaced due to HIPAA requirements.)

In certain instances, two-digit modifiers are applicable. They should be placed after the five-position procedure code. Modifiers are found in CPT-4. Additional modifiers are shown below:

| Code | Description |
|---|---|
| AA | Anesthesia service personally furnished by anesthesiologist |
| AD | Medical direction of CRNAs employed by anesthesiologist (not more than four employees) |
| AP | Determination of refractive state was not performed in the course of diagnostic ophthalmological examination |
| AS | Services of physician assistant: assisting at surgery |
| EP | Services provided as the result of a Care for Kids (EPSDT) examination |
| GF | Non-physician service (e.g., nurse-practitioner) |
| LS | FDA-monitored intraocular lens implant |
| LT | Left side (used to identify procedures performed on the left side of the body) |
| QY | Medical direction of CRNAs employed by hospital (not more than four CRNAs) |
| QZ | No medical direction of CRNAs employed by anesthesiologist |
| RP | Replacement of lost or broken frames or lenses |
| RT | Right side (used to identify procedures performed on the right side of body) |
| TC | Technical component for radiology and some diagnostic procedures |

| Code | Description |
|---|---|
| U1 | Care for Kids (EPSDT) physical with referral |
| U2 | Services of physician assistant: Do not use for assistant at surgery or injections, radiology, or pathology services. Use for medical visits; i.e., hospital, office, or nursing facility services. |
| U4 | Mental retardation testing (used with CPT codes 96100-96117) |
| VP | Diagnosis of aphakia |
| 32 | Annual routine physical required for RCF resident |

The codes to be used for optical services, psychological services, injections, medical supplies, and other miscellaneous services are listed below.

## A. Injections

Physicians are reimbursed separately for injections and for the administration of injections. Use current CPT or HCPCS national Level 2 codes for injections. If you cannot identify a specific code to use, refer to "not otherwise classified" codes, such as J3490. When using an "unspecified" code, you must give the description of the drug, including the strength and the dosage.

Immunizations are usually given in conjunction with a medical service. When an immunization is the only service performed, you may list a minimal service in addition to the injection. Immunization procedures include the supply of related materials.

You must provide Medicaid immunizations under the Vaccines for Children Program (VFC). Vaccines available through the VFC program are:

| Code | Description |
|---|---|
| 90702 | Diphtheria and tetanus toxoids (DT) vaccine |
| 90700 | Diphtheria, tetanus, acellular pertussis (DTaP) |
| 90748 | Hemophilus influenza B (HIB) and hepatitis B vaccine |
| 90723 | Diphtheria, tetanus toxoids, & acellular pertussis (DTaP), Hepatitis B poliovirus (IPV) vaccine |
| 90721 | Diphtheria, tetanus toxoids, & acellular pertussis (DTaP), hemophilus influenza B (HIB) vaccine |
| 90645 | Hemophilus influenza B (HIB) HbOC conjugate (4 dose schedule) |
| 90646 | Hemophilus influenza B (HIB) PRP-D conjugate (booster only) |
| 90647 | Hemophilus influenza B (HIB) PRP-Omp conjugate (3 dose schedule) |
| 90648 | Hemophilus influenza B (HIB) PRP-T conjugate (4 dose schedule) |
| 90743 | Hepatitis B vaccine; adolescent (two-dose schedule), for intramuscular use |
| 90744 | Hepatitis B vaccine; pediatric/adolescent dosage (three-dose schedule), for intramuscular use |
| 90657 | Influenza vaccine, 6-35 months |
| 90658 | Influenza vaccine, 3 yrs & older |
| 90707 | Measles, mumps, and rubella virus vaccine (MMR), live |
| 90669 | Pneumococcal conjugate, children under 5 |
| 90713 | Poliovirus vaccine (IPV) |
| 90718 | Tetanus and diphtheria toxoids (TD) absorbed, for use in patients aged seven years or older, for intramuscular or jet injection |
| 90716 | Varicella vaccine |

When a child receives a vaccine outside of the VFC schedule, Medicaid will provide reimbursement.

Bill code 90471 or 90472 for vaccine administration in addition to the CPT code. For VFC vaccine, the charges in field 24F should be "0."

## B. Medical Supplies

| Code | Description |
|---|---|
| A4460 | Ace bandage, 2-inch, 2 1/2-inch , 3-inch, 4-inch, or 6-inch width |
| A4565 | Arm sling |
| A4570 | Arm splint |
| L0140 | Cervical collar, semirigid, adjustable (plasticollar) |
| A4266 | Diaphragm |
| S8450 | Finger splint |
| W0357 | Gastrostomy button, each |
| J7300 | Intrauterine device (IUD) |
| L1830 | KO, immobilizer, canvas longitudinal |
| L0500 | LSO (lumbo-sacral surgical support), flexible custom-fitted (men or women) |
| 99082 | Mileage for practitioners |
| A4572 | Rib belt |
| L3660 | SO, figure of “8” design abductin restrainer, canvas and webbing |
| L3260 | Surgical boots |
| L8300 | Trusses, single with standard pad |

## C. Miscellaneous Services

| Code | Description |
|---|---|
| 01964 | Anesthesia for legal (therapeutic) abortion |
| 00940 | Anesthesia for excision of cervical stump or myomectomy |
| 00851 | Anesthesia for tubal ligation or transection |

Wart removal is a surgical procedure and is payable based on the procedure code submitted.

# D. Nursing Home Visits

## 1. Nursing Facility Assessments

| Code | Description |
|---|---|
| 99301 | Comprehensive nursing facility assessments; requires these three components:<br>• a detailed interval history,<br>• a comprehensive examination, and<br>• medical decision making that is straightforward or of low complexity. |
| 99302 | Comprehensive nursing facility assessments; requires these three components:<br>• a detailed interval history,<br>• a comprehensive examination, and<br>• medical decision making of moderate to high complexity. |
| 99303 | Comprehensive nursing facility assessments; requires these three components.<br>• a comprehensive history,<br>• a comprehensive examination, and<br>• medical decision making of moderate to high complexity. |

## 2. Subsequent Nursing Facility Care

| Code | Description |
|---|---|
| 99311 | Subsequent nursing facility care, per day; requires at least two of these three components:<br>• a problem-focused interval history,<br>• a problem-focused examination, or<br>• medical decision making that is straightforward or of low complexity. |
| 99312 | Subsequent nursing facility care, per day; requires at least two of these three components:<br>• an expanded problem-focused interval history,<br>• an expanded problem-focused examination, or<br>• medical decision making of moderate complexity. |

| Code | Description |
|---|---|
| 99313 | Subsequent nursing facility care, per day; requires at least two of these three components:<br>• a detailed interval history,<br>• a detailed examination, or<br>• medical decision making of moderate to high complexity. |

## E. Obstetrical Services

### 1. Risk Assessment

| Code | Description |
|---|---|
| 99420 | Completion of *Medicaid Prenatal Risk Assessment*, form 470-2942. |

### 2. Delivery, Antepartum, and Postpartum Care

| Code | Description |
|---|---|
| 59400 | Routine obstetric care, including antepartum care, vaginal delivery (with or without episiotomy or forceps), and postpartum care. |
| H1005* | High-risk obstetric care, including antepartum care, vaginal delivery (with or without episiotomy or forceps), and postpartum care. |
| 59409 | Vaginal delivery only (with or without episiotomy or forceps). |
| 59410 | Vaginal delivery only (with or without episiotomy or forceps), including postpartum care. |
| 59425 | Antepartum care only; 4-6 visits. |
| H1001 | High-risk antepartum care only; 4-6 visits. |
| 59426 | Antepartum care only; 7 or more visits. |
| H1001 | High-risk antepartum care only; 7 or more visits. |
| 59430 | Postpartum care only (separate procedure). |
| | **Cesarean Delivery** |
| 59510 | Routine obstetric care, including antepartum care, cesarean delivery, and postpartum care. |
| H1005* | High-risk obstetric care, including antepartum care, cesarean delivery, and postpartum care. |
| 59514 | Cesarean delivery only. |
| 59515 | Cesarean delivery only, including postpartum care. |

*Use these codes in addition to the CPT codes reflecting routine obstetrical care.

Bill 59425 when four to six antepartum care visits are provided **and** delivery services are **not** also provided.

Bill 59426 when seven or more antepartum care visits are provided **and** delivery services are **not** also provided.

Bill using evaluation and management CPT codes for one to three antepartum care visits when delivery services are not also provided. Use the modifier "OB" with the evaluation and management codes to obtain increased reimbursement.

Also bill local code H1001, high-risk antepartum care only (separate procedure), when the risk assessment so reflects. Maintain a copy of the completed *Medicaid Prenatal Risk Assessment*, form 470-2942, in your records.

Postpayment reviews of evaluation and management CPT codes are conducted to ensure the billing of appropriate levels of service. Routine antepartum obstetrical visits with no complications typically are at the level of CPT code 99212. When higher levels of evaluation and management codes are used, your records must document the reasons a higher code was used.

## F. Optical Services

### 1. Professional Services

**Note:** Refer to CPT Manual for additional codes related to professional service.

| Code | Description |
|---|---|
| | **Examinations** |
| 92015 | Refraction only (use only when eye exam is billed to Medicare) |
| 92002 | Intermediate exam, new patient (nonroutine) |
| 92012 | Intermediate exam, established patient (nonroutine) |
| 92004 | Comprehensive exam, new patient (nonroutine) |
| 92014 | Comprehensive exam, established patient (nonroutine) |

| Code | Description |
|---|---|
| | **Contact Fitting** |
| W2023 | Dispense and fit contact |
| | **Frame, Service, Parts, and Case** |
| W0013 | Case for glasses |
| W2022 | Dispense and fit new frames |
| W2006 | Repair of frames, parts and labor (when new glasses are not dispensed) |
| V2025 | Small frame (use for wraparound frames for children up to two years of age) |
| V2020 | Total frame |
| | **Lens Service** |
| W2021 | Dispense and fit new lenses |
| W2005 | Repair of lenses, parts, and labor (when new glasses are not dispensed) |

**2. Materials**

| Code | Description |
|---|---|
| | **Single-Vision Lenses** |
| V2100 | Sphere, single vision, plano to plus or minus 4.00D, per lens |
| V2101 | Sphere, single vision, plus or minus 4.12 to plus or minus 7.00D, per lens |
| V2102 | Sphere, single vision, plus or minus 7.12 to plus or minus 20.00D, per lens |
| V2103 | Spherocylinder, single vision, plano to plus or minus 4.00D sphere, .12 to 2.00 D cylinder, per lens |
| V2104 | Spherocylinder, single vision, plano to plus or minus 4.00D sphere, 2.12 to 4.00D cylinder, per lens |
| V2105 | Spherocylinder, single vision, plano to plus or minus 4.00D sphere, 4.25 to 6.00D cylinder, per lens |
| V2106 | Spherocylinder, single vision, plano to plus or minus 4.00D sphere, over 6.00D cylinder, per lens |
| V2107 | Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00D sphere, .12 to 2.00D cylinder, per lens |

| Code | Description |
|---|---|
| V2108 | Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00D sphere, 2.12 to 4.00D cylinder, per lens |
| V2109 | Spherocylinder, single vision, plus or minus 4.25 to plus or minus 7.00D sphere, 4.25 to 6.00D cylinder, per lens |
| V2110 | Spherocylinder, single vision, plus or minus 4.25 to 7.00D sphere, over 6.00D cylinder, per lens |
| V2111 | Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00D sphere, .25 to 2.25D cylinder, per lens |
| V2112 | Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00D sphere, 2.25 to 4.00D cylinder, per lens |
| V2113 | Spherocylinder, single vision, plus or minus 7.25 to plus or minus 12.00D sphere, 4.25 to 6.00D cylinder, per lens |
| V2114 | Spherocylinder, single vision, sphere over plus or minus 12.00D, per lens |
| V2118 | Aniseikonic lens, single vision, per lens |
| V2710 | Slab off prism, glass or plastic, per lens |
| V2110 | Lenses with a correction of plus or minus 6 diopters, per lens |

**Bifocal-Vision Lenses**

| | |
|---|---|
| V2200 | Sphere, bifocal, plano to plus or minus 4.00D, per lens |
| V2201 | Sphere, bifocal, plus or minus 4.12 to plus or minus 7.00D, per lens |
| V2202 | Sphere, bifocal, plus or minus 7.12 to plus or minus 20.00D, per lens |
| V2203 | Spherocylinder, bifocal, plano to plus or minus 4.00D sphere, .12 to 2.00D cylinder, per lens |
| V2204 | Spherocylinder, trifocal, plano to plus or minus 4.00D sphere, 2.12 to 4.00D cylinder, per lens |
| V2205 | Spherocylinder, bifocal, plano to plus or minus 4.00D sphere, 4.25 to 6.00D cylinder, per lens |
| V2206 | Spherocylinder, bifocal, plano to plus or minus 4.00D sphere, over 6.00D cylinder, per lens |
| V2207 | Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00D sphere, .12 to 2.00D cylinder, per lens |
| V2208 | Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00D sphere, 2.12 to 4.00D cylinder, per lens |

| Code | Description |
|---|---|
| V2209 | Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00D sphere, 4.25 to 6.00.D cylinder, per lens |
| V2210 | Spherocylinder, bifocal, plus or minus 4.25 to plus or minus 7.00D sphere, 6.00D cylinder, per lens |
| V2211 | Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00D sphere, 25 to 2.25D cylinder, per lens |
| V2212 | Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00D sphere, 2.25 to 4.00D cylinder, per lens |
| V2213 | Spherocylinder, bifocal, plus or minus 7.25 to plus or minus 12.00D sphere, 4.25 to 6.00 cylinder, per lens |
| V2214 | Spherocylinder, bifocal, sphere over plus or minus 12.00D per lens |
| V2218 | Aniseikonic, per lens, bifocal |
| V2219 | Bifocal seg width over 28MM per lens |
| V2220 | Bifocal add over 3.25D, per lens |
| V2710 | Slab off prism, glass or plastic |
| V2110 | Lenses with a correction of plus or minus 6 diopters, per lens |
| | **Trifocal-Vision Lenses** |
| V2300 | Sphere, trifocal, plano to plus or minus 4.00D, per lens |
| V2301 | Sphere, trifocal, plus or minus 4.12 to plus or minus 7.00D, per lens |
| V2302 | Sphere, trifocal, plus or minus 7.12 to plus or minus 20.00D, per lens |
| V2303 | Spherocylinder, trifocal, plano to plus to minus 4.00D sphere, .12 to 2.00D cylinder, per lens |
| V2304 | Spherocylinder, trifocal, plano to plus or minus 4.00D sphere, 2.25 to 4.00D cylinder, per lens |
| V2310 | Spherocylinder, trifocal, plus to minus 4.25 to plus or minus 7.00D sphere, over 6.00D cylinder, per lens |
| V2311 | Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00D sphere, .25 to 2.25D cylinder, per lens |
| V2312 | Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00D sphere, 2.25 to 4.00D cylinder, per lens |
| V2313 | Spherocylinder, trifocal, plus or minus 7.25 to plus or minus 12.00D sphere, 4.25 to 6.00 cylinder, per lens |
| V2314 | Spherocylinder, trifocal, sphere over plus or minus 12.00D, per lens |
| V2318 | Aniseikonic lens, trifocal, per lens |
| V2319 | Trifocal seg width over 28MM, per lens |
| V2320 | Trifocal add over 3.25D, per lens |

| Code | Description |
|---|---|
| V2710 | Slab off prism, glass or plastic, per lens |
| V2110 | Lenses with a correction of plus or minus 6 diopters, per lens |
| | **Aphakia Lenses** |
| V2115 | Lenticular, myodisc, per lens, single vision |
| V2116 | Lenticular, nonaspheric, per lens, single vision |
| V2117 | Lenticular aspheric, per lens, single vision |
| V2215 | Lenticular, myodisc, per lens, bifocal |
| V2216 | Lenticular, nonaspheric, per lens, bifocal |
| V2217 | Lenticular, aspheric lens, bifocal |
| V2315 | Lenticular, myodisc, per lens, trifocal |
| V2316 | Lenticular, nonaspheric, per lens, bifocal |
| V2317 | Lenticular, aspheric, per lens, trifocal |
| | **Contact Lenses** |
| V2500 | Contact lens, PMMA, spherical, per lens |
| V2501 | Contact lens, PMMA, toric or prism ballast, per lens |
| V2502 | Contact lens, PMMA, bifocal, per lens |
| V2510 | Contact lens, gas permeable, spherical, per lens |
| V2305 | Spherocylinder, trifocal, plano to plus or minus 4.00D sphere, 4.25 to 6.00D cylinder, per lens |
| V2306 | Spherocylinder, trifocal, plano to plus or minus 4.00D sphere, over 6.00 cylinder, per lens |
| V2307 | Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00D sphere, .12 to 2.00D cylinder, per lens |
| V2308 | Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00D sphere, 2.12 to 400D cylinder, per lens |
| V2309 | Spherocylinder, trifocal, plus or minus 4.25 to plus or minus 7.00D sphere, 4.25 to 6.00D cylinder, per lens |
| V2511 | Contact lens, gas permeable, toric, prism, ballast, per lens |
| V2512 | Contact lens, gas permeable, bifocal, per lens |
| V2513 | Contact lens, gas permeable, extended wear, per lens |
| V2520 | Contact lens, hydrophilic, spherical, per lens |
| V2521 | Contact lens, hydrophilic toric, or prism ballast, per lens |
| V2522 | Contact lens, hydrophilic, bifocal, per lens |
| V2530 | Contact lens, scleral, per lens |

**Note:** For reporting purposes, modifier “VP” may be used after the procedure code to reflect a diagnosis of aphakia.

**Subnormal Visual Aid**

Prior authorization is required for subnormal visual aids where near visual acuity is better than 20/100 at 16 inches, 2M print. Use codes below.

| | |
|---|---|
| V2600 | Hand-held low-vision aids and other non-spectacle-mounted aids |
| V2610 | Single lens spectacle-mounted low-vision aids |
| V2615 | Telescopic and other compound lens systems, including distance vision telescopic, near vision telescopic, and compound microscopic lens systems |

Prior authorization is not required for subnormal visual aids where near visual acuity is less than 20/100. Use codes below.

| | |
|---|---|
| V2600 | Hand-held low-vision aid and other non-spectacle-mounted aids |
| V2610 | Single-lens spectacle-mounted low-vision aids |
| V2615 | Telescopic and other compound lens system, including distance-vision telescopic, near-vision telescopic, and compound microscopic lens system |

**Other Service**

| | |
|---|---|
| A4262 | Temporary, absorbable lacrimal duct implant, each |
| A4253 | Permanent, long term, non-disposable lacrimal duct implant, each |

Pages 111 through 128 are reserved for future use.

## G. Osteopathic Manipulation

| Code | Description |
|---|---|
| 97260 | Manipulations (cervical, thoracic, lumbosacral, sacroiliac, hand, wrist) (separate procedure), performed by physician; one area |
| 97261 | Manipulation, each additional area |
| 98925 | Osteopathic manipulative therapy; one to two body regions involved |
| 98926 | Osteopathic manipulative therapy; three to four body regions involved |
| 98927 | Osteopathic manipulative therapy; five to six body regions involved |
| 98928 | Osteopathic manipulative therapy; seven to eight body regions involved |
| 98929 | Osteopathic manipulative therapy; nine to ten body regions involved |

# H. Psychiatric Services

## 1. Interview or Examination

90801 Psychiatric diagnostic interview or examination, including history, mental status, or disposition by psychiatrist, per 15 minutes.

(May include communication with family or other sources or ordering and medical interpretation of laboratory or other medical diagnostic studies. In certain circumstances other informants may be seen in lieu of the patient.)

W0802 Psychiatric diagnostic interview examination, including history, mental status, or disposition by psychologist, social worker or psychiatric nurse, per 15 minutes.

(May include communication with family or other sources or ordering and medical interpretation of laboratory or other medical diagnostic studies. In certain circumstances other informants may be seen in lieu of the patient.)

W0827 Brief interview by psychiatrist, 15 minutes.

W9221 History and physical examination by non-psychiatrist.

## 2. Psychological Testing

96100 Psychological testing with interpretation and report, per hour
W0854 Testing for degree of mental retardation
W0855 Evaluation for mental retardation
W9221 Inpatient medical evaluation for a mental health diagnosis

### 3. Individual Psychotherapy

| | |
|---|---|
| 90841 | Individual medical psychotherapy with continuing medical diagnostic evaluation and drug management when indicated, including psychoanalysis or insight-oriented, behavior-modifying, or supportive psychotherapy, by psychiatrist, per 15 minutes. |
| 90843 | Medicaid does not use this code. Refer to 90841 |
| 90844 | Medicaid does not use this code. Refer to 90841 |
| W0844 | Individual psychotherapy by psychologist, per 15 minutes |
| W0845 | Individual psychotherapy by social worker, per 15 minutes |
| W0846 | Individual psychotherapy by psychiatric nurse, per 15 minutes |

### 4. Family Therapy

| | |
|---|---|
| W0866 | Family therapy by psychiatric nurse |
| W0867 | Family therapy by social worker |
| W0868 | Family therapy by psychologist |
| W0869 | Family therapy by physician |

### 5. Group Psychotherapy

| | |
|---|---|
| W0856 | Group psychotherapy, by psychiatrist, per hour |
| W0857 | Group psychotherapy, by psychologist, per hour |
| W0858 | Group psychotherapy, by social worker, per hour |
| W0859 | Group psychotherapy, by psychiatric nurse, per hour |
| W0870 | Group psychotherapy, by two psychiatrists, per hour |
| W0871 | Group psychotherapy, by psychiatrist and psychologist, per hour |
| W0872 | Group psychotherapy, by two psychologist, per hour |
| W0873 | Group psychotherapy, by social worker and psychiatrist, per hour |
| W0874 | Group psychotherapy, by social worker and psychologist, per hour |
| W0875 | Group psychotherapy, by two social workers, per hour |
| W0876 | Group psychotherapy, by psychiatric nurse and psychiatrist, per hour |
| W0877 | Group psychotherapy, by psychiatric nurse and psychologist, per hour |
| W0878 | Group psychotherapy, by psychiatric nurse and social worker, per hour |
| W0879 | Group psychotherapy, by two psychiatric nurses, per hour |
| W0886 | Group psychotherapy, by psychiatrist, per 1½ hours |

W0887 Group psychotherapy, by psychologist, per 1½ hours
W0888 Group psychotherapy, by social worker, per 1½ hours
W0889 Group psychotherapy, by psychiatric nurse, per 1½ hours
W0890 Group psychotherapy, by two psychiatrists, per 1½ hours
W0891 Group psychotherapy, by psychiatrist and psychologist, per 1½ hours
W0892 Group psychotherapy, by two psychologist, per 1½ hours
W0893 Group psychotherapy, by social worker and psychiatrist, per 1½ hours
W0894 Group psychotherapy, by social worker and psychologist, per 1½ hours
W0895 Group psychotherapy, by two social workers, per 1½ hours
W0896 Group psychotherapy, by psychiatric nurse and psychiatrist, per 1½ hours
W0897 Group psychotherapy, by psychiatric nurse and psychologist, per 1½ hours
W0898 Group psychotherapy, by psychiatric nurse and social worker, per 1½ hours
W0899 Group psychotherapy, by two psychiatric nurses, per 1½ hours

Two-position modifiers must follow the five-position procedure code, if applicable. Group therapy codes must show the number of people in the group. (See Item 7, below.) For example, enter "W0857-08" to indicate group psychotherapy by a psychologist with eight group members.

**6. Miscellaneous Therapy**

90835 Narcosynthesis for psychiatric diagnostic and therapeutic purposes, e.g., sodium amobarbital (Amytal) interview
90862 Pharmacological management, including prescription, use, and review of medication with no more than minimal medical psychotherapy
90870 Electroconvulsive therapy, single seizure
90871 Electroconvulsive therapy, multiple seizures
W0511 Psychotropic drug administration and brief office call

**NOTE:** List the number of treatments in the "Full Description" area of the claim form.

**7. Billing Notes**

Service will be reimbursed on the basis of time. Enter the number of units in the Units column, with one unit equal to the time shown in the description for the procedure code. For example, the unit for W0844 (individual psychotherapy) is 15 minutes. For W0856 (group therapy), the unit is one hour.

Round the units of service to the nearest unit. For example, 1 hour and 7 minutes of individual psychotherapy is rounded to 1 hour; and 1 hour and 8 minutes is rounded to 1 hour and 15 minutes.

Payment for group therapy is based on the actual number of persons who comprise the group, but not less than six. For example, if eight persons comprise the group, payment will be based on this number. However, if the group consists of four persons, payment will nevertheless be based on six persons. Enter the number of people in the group as a two-digit modifier directly after the procedure code.

# IX. CONTENT OF SCREENING EXAMINATION

A screening examination must include at least the following:

- Comprehensive health and developmental history, including an assessment of both physical and mental health development. This includes:
  - A developmental assessment.
  - An assessment of nutritional status.
- A comprehensive unclothed physical examination. This includes:
  - Physical growth.
  - A physical inspection, including ear, nose, mouth, throat, teeth, and all organ systems, such as pulmonary, cardiac, and gastrointestinal.
- Appropriate immunizations according to age and health history as recommended by the Vaccines for Children Program.
- Health education, including anticipatory guidance.
- Hearing and vision screening.
- Appropriate laboratory tests. These shall include:
  - Hematocrit or hemoglobin.
  - Rapid urine screening.
  - Lead toxicity screening for all children ages 6 to 72 months.
  - Tuberculin test, when appropriate.
  - Hemoglobinopathy, when appropriate.
  - Serology, when appropriate.
- Direct dental referral for children over age 12 months.

# A. History and Guidance

## 1. Comprehensive Health and Developmental History

A comprehensive health and developmental history is a profile of the patient's medical history. It includes an assessment of both physical and mental health development. Take the patient's medical history from the patient, if age-appropriate, or from a parent, guardian, or responsible adult who is familiar with the patient's history.

Take or update a comprehensive health and developmental history at every initial or periodic EPSDT screening visit. Include the following:

- Identification of specific concerns.
- Family history of illnesses.
- The client's history of illnesses, diseases, allergies, and accidents.
- Information about the client's social or physical environment which may effect the client's overall health.
- Information on current medications or adverse reaction/responses due to medications.
- Immunization history.
- Developmental history to determine whether development falls within a normal range of achievement according to age group and cultural background.
- Identification of health resources currently used.

**2. Developmental Screening**

The primary purpose of screening data is to identify children who need more in-depth evaluation. The developmental component for young children should include the following four areas:

- Speech and language,
- Fine and gross motor skills,
- Cognitive skills, and
- Social and emotional behavior.

In screening children from birth to six years of age, it is recommended that you select recognized instruments, such as the Denver II, that have written standardized procedures for administration, scoring, and interpretation. Criteria for referral vary with the instrument or procedures used.

As the child grows through school age, focus on visual-motor integration, visual-spatial organization, visual sequential memory, attention skills, auditory processing skills, and auditory sequential memory.

The adolescent population presents a different developmental challenge. Many of the more readily apparent developmental problems should have been identified and be under appropriate treatment. Focus screening on such areas of special concern as potential presence of learning disabilities, peer relations, psychological or psychiatric problems, and vocational skills.

No list of specific instruments is required for identifying developmental problems of adolescents. However, the following principles should be considered:

- Collect information on the child's or adolescent's usual functioning, as reported by the child, parents, teacher, health professional, or other familiar person.

- In developmental screening, incorporate and review this information in conjunction with other information gathered during the physical exam. Make an objective professional judgment as to whether the child is within the expected ranges. Review the developmental progress of a child not in an isolated context, but as a component of overall health and well-being, given the child's age and culture.

- Screening should be culturally sensitive and valid. Do not dismiss or excuse potential problems improperly based on ground of culturally appropriate behavior. Do not initiate referrals improperly for factors associated with cultural heritage.

- Screening should not result in a label or premature diagnosis being assigned to a child. Report only that a condition was referred or that diagnostic treatment services is needed. Results of initial screening should not be accepted as conclusions and do not represent diagnosis.

When you or the parent have concerns or questions regarding the functioning of the child in relation to expected ranges of activities after screening, make a referral for developmental assessment by professionals trained in the use of more elaborate instruments and structured tests.

**3. Mental Health Assessment**

Mental health assessment should capture in important and relevant information about the patient as a person. It may include a psychosocial history such as:

- The patient's life-style, home situation, and "significant others."

- A typical day--how the patient spends the time from getting up to going to bed.

- Religious and health beliefs of the family relevant to perceptions of wellness, illness, and treatment, and the patient's outlook on the future.

- Sleep--amount and patterns during day and at night; bedtime routines; type and location of bed; and nightmare, terrors, and somnambulating.

- Toileting--methods of training used, when bladder and bowel control attained, occurrence of accidents or of enuresis or encopresis, and parental attitudes.

- Speech--hesitation, stuttering, baby talk, lisping, and estimate of number of words in vocabulary.

- Habits--bed-rocking, head-banging, tics, thumb-sucking, pica, ritualistic behavior, and use of tobacco, alcohol, or drugs.

- Discipline--parental assessment of child's temperament and response to discipline, methods used and their success or failure, negativism, temper tantrums, withdraw, and aggressive behavior.

- Schooling experience with day care, nursery school, and kindergarten; age and adjustment on entry; current parental and child satisfaction; academic achievement; and school's concerns.

- Sexuality--relations with members of opposite sex; inquisitiveness regarding conception, pregnancy, and girl-boy differences; parental responses to child's questions and the sex education they have offered regarding masturbation, menstruation, nocturnal emissions, development of secondary sexual characteristics, and sexual urges; and dating patterns.

- Personality--degree of independence; relationship with parents, siblings, and peers; group and independent activities and interests, congeniality; special friends (real or imaginary); major assets and skills; and self image.

Source: Boyle Jr., W.E. and Hoekelman, R.A. The Pediatric History, In Hoekelman, R.A. ed. *Primary Pediatric Care*, 1992.

Form 470-3165, Child Mental Health Screen, is a screening tool that has been developed for use in the Iowa EPSDT program. A facsimile follows. Use of this form is optional. Create supplies as needed from the sample in this manual.

Iowa Department of Human Services

# CHILD MENTAL HEALTH SCREEN

[This form is for screening purposes only. It is not to be used for diagnosis.]

| Child's Name | Date | Birth Date | Medicaid No. |
|---|---|---|---|
| Medicaid Provider Agency: | | | |

Source of Information: ❑ Family Interview ❑ Child Interview ❑ Case Review

Begin with the child's current age. Check "YES" or "NO" for each question or if information is not available, leave blank. Continue with the questions in the earlier age groups to determine whether any of the items occurred during that specific age range. For example, if you are screening a 9-year old, begin with Age Group 6-10 and answer all of the questions. If the child has not been sexually abused between the ages of 6 and 10, check "NO." Move to Age Group 0-5. You are told the child was sexually abused at age 4. Mark "YES" for sexual abuse occurring during this age range. There is a section for "OTHER CONCERNS" on page 3.

| ***Age 17 to 21*** | ***Yes*** | ***No*** |
|---|---|---|
| | | |
| 1. Has had poor performance in school or at work | | |
| 2. Has frequent mood swings or confused thoughts | | |
| 3. Has attempted to hurt self | | |
| 4. Has been assaultive to others | | |
| 5. Has had unwed pregnancy | | |
| 6. Has been referred to criminal justice system | | |
| 7. Has had problems with alcohol and/or other drugs | | |
| 8. In danger of placement or already placed out of home | | |

| ***Age 11 to 16*** | ***Yes*** | ***No*** |
|---|---|---|
| | | |
| 1. Has difficulties in school (attendance, concentration, or discipline problems) | | |
| 2. Has frequent mood swings or confused thoughts | | |
| 3. Has attempted to hurt self | | |
| 4. Has been assaultive to others | | |
| 5. Has had unwed pregnancy | | |
| 6. Has been referred to juvenile court | | |
| 7. Has had problems with alcohol and/or other drugs | | |
| 8. In danger of placement or already placed out of home | | |

| ***Age 6 to 10*** | ***Yes*** | ***No*** |
|---|---|---|
| | | |
| 1. Has difficulties in school (attendance, concentration, or discipline problems) | | |
| 2. Frequently withdrawn or noncommunicative | | |
| 3. Has frequent and uncontrollable temper tantrums | | |
| 4. Expresses feelings of sadness and wanting to hurt self | | |
| 5. Assaultive to people or deliberately cruel to animals | | |
| 6. Has used alcohol and/or other drugs | | |
| 7. Has been physically or sexually abused or has abused others | | |
| 8. In danger of placement or already placed out of home | | |

| ***Age 0 to 5*** | ***Yes*** | ***No*** |
|---|---|---|
| | | |
| 1. Poor appetite or overeating | | |
| 2. Restless sleeper (awake all night or having nightmares) | | |
| 3. Hyperactive, easily distracted, short attention span | | |
| 4. Sets fires | | |
| 5. Has major physical or developmental problems | | |
| 6. Any aggressive behaviors unusual for his/her age | | |
| 7. Has been physically or sexually abused | | |
| 8. In danger of placement or already placed out of home | | |

| ***For All Age Groups*** | ***Yes*** | ***No*** |
|---|---|---|
| | | |
| 1. Has family or friends available or willing to help in case of emergency | | |
| 2. Family has coped well with the child's problems | | |
| 3. Child has coped well with major traumas (divorce, death, etc.) | | |
| 4. Has sought professional help in the past | | |

Any other concerns not noted above?

**CONCLUSIONS OF SCREENING**

The frequency and severity of the problem and the screener's professional judgment and knowledge of the child and family should be the basis for determining whether the suspected problem requires a referral for assessment.

| | | |
|---|---|---|
| In your opinion, does the child need a mental health referral? | ❑ YES | ❑ NO |
| Is this an emergency referral? | ❑ YES | ❑ NO |
| Has the family or child agreed to a mental health referral for assessment? | ❑ YES | ❑ NO |

Recommendation for Client:

| |
|---|
| *Name of Agency* |

| |
|---|
| *Date of Referral* |

| |
|---|
| *Signature and Title of the Person Completing the Form* |

[The information on this form cannot be disclosed without the permission of the client.]

**4. Health Education/Anticipatory Guidance**

Health education which includes anticipatory guidance is an essential component of screening services. Provide it to parents and youth (if age-appropriate) at each screening visit. Design it to:

- Assist the parents and youth in understanding what to expect in terms of the child's development.
- Provide information about the benefits of healthy lifestyles and practices as well as injury and disease prevention.

Health education must be age-appropriate, culturally competent, and geared to the particular child's medical, developmental, and social circumstances. Four lists of age-related topics recommended for discussion at screenings are included below.

Anticipatory guidance and health education recommended topics are included in the *1994 Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, Arlington, VA. This publication is available from the National Center for Education in Maternal and Child Health (703) 821-8955, ext. 254 or 265.

View this list as a guideline only. It does not require the inclusion of topics which are inappropriate for the child or limit topics which are appropriate for the child.

## Suggested Health Education Topics: Birth - 18 Months

| | |
|---|---|
| ***Dental Health*** | |
| Breast or bottle feeding discontinued at 12 months | Teething |
| Education on fluorides and supplements | Thumb or finger sucking |
| Infant oral care | Toothbrushing |
| Nursing bottle mouth | First dental visit |
| Pacifiers | Use of cup |
| ***Injury Prevention*** | |
| Child care options while parents farm | Lock up farm chemicals |
| Child safety seat restraint | Restricted play areas on the farm |
| Child safety seats | Smoke detectors |
| Electric outlets | Stairway gates, walkers, cribs |
| Farm animals | Syrup of ipecac, poison control |
| Hot water heater temperature | Telephone numbers |
| Ingestants, pieces of toys, popcorn, peanuts, hot dogs, powder | |
| ***Mental Health*** | |
| Adjustment to new baby | Child care |
| Balancing home, work, and school | Sibling rivalry |
| Caretakers expectations of infant development | Support from spouse and friends |
| ***Nutrition*** | |
| Bottle propping | Managing meal time behavior |
| Breast or formula feeding to 1 year | Self feeding |
| Burping | Snacks |
| Fluid needs | Weaning |
| Introduction of solid foods 4-6 months | |
| ***Other Preventive Measures*** | |
| Bowel patterns | Fever |
| Care of respiratory infections | Hiccoughs |
| Crying or colic | Importance of well-child visits |
| Effects of passive smoking | Back sleeping |

## Suggested Health Education Topics: 2 - 5 Years

| | |
|---|---|
| ***Dental Health*** | |
| Bottle feeding discontinued at 12 months | Importance of dental exam |
| Dental injuries or emergencies | Sealants on permanent 6 and 12 year molars |
| Dietary habits and health food | |
| Fluoride | Thumb or finger sucking |
| ***Injury Prevention*** | |
| Booster car seat | Play equipment |
| Burns and fire | Purchase of bicycles |
| Cover manure pits | Put up warning signs |
| Danger of corn cribs and grain bins | Restricted play areas |
| Dangers of accessible farm chemicals | Street danger |
| Farm hazards | Teach child how to get help |
| Grain auger danger | Toys |
| Importance of protective helmets | Tricycles |
| Livestock danger | Walking to school |
| Machinery safety | Water safety |
| No extra riders on tractor | |
| ***Mental Health*** | |
| Adjustment to increasing activity of child | Child care |
| Balancing home, work, and school | Sibling rivalry |
| ***Nutrition*** | |
| Appropriate growth pattern | Managing meal time behavior |
| Appropriate intake for age | Physical activity |
| Control issues over food | Snacks |
| ***Other Preventive Measures*** | |
| Care of illness | School readiness |
| Clothing | Sleep |
| Common habits | Toilet training |
| Importance of well-child visits | |

## Suggested Health Education Topics: 6 - 12 Years

| | |
|---|---|
| ***Dental Health*** | |
| Dental referral | Mouth guards |
| Dental emergency/injury | Periodontal (gum) disease (at 10 years) |
| Flossing (at 10 years) | Sealants |
| Fluoride supplement (discontinue at 13 years) | Thumb/finger sucking |
| | Toothbrushing |
| Healthy snacks | |
| ***Injury Prevention*** | |
| Bike (helmet) safety | Livestock danger |
| Car safety | Machinery safety |
| CPR training | Mowing safety classes |
| Dangers of farm ponds and creeks | Refuse rides with strangers |
| Electric fences | Self-protection tips |
| Farm safety day camps | Sports safety |
| Fire safety | Street safety |
| Gravity flow wagons | Tractor training courses |
| Gun and hunter safety | Water safety |
| Importance of knowing emergency numbers and directions to their farm | |
| ***Mental Health*** | |
| Discipline | Peer pressure and adjustment |
| Emotional, physical, and sexual development | School-related concerns |
| | Sibling rivalry |
| ***Nutrition*** | |
| Appropriate intake for age | Managing meal time behavior |
| Breakfast | Peer influence |
| Child involvement with food decisions | Physical activity |
| Food groups | Snacks |
| Inappropriate dietary behavior | |
| ***Other Preventive Measures*** | |
| Adequate sleep | Preparation of girls for menarche |
| Clothing | Sports |
| Exercise | Stress |
| Hygiene | TV viewing |
| Importance of well-child visits | |

## Suggested Health Education Topics: Adolescent (13 - 21 Years)

| | |
|---|---|
| ***Dental Health*** | |
| Dental emergency and injury prevention | Hygiene regular brushing, flossing, and dental visits |
| Hazard of smokeless tobacco | |
| Healthy snacks | Periodontal disease dental carries |
| ***Development*** | |
| Normal biopsychosocial changes of adolescence | |
| ***Gender Specific Health*** | |
| Abstinence education | Sexual development gender specific |
| Contraception, condom use | Sexual orientation |
| HIV counseling or referral | Sexual responsibility, decision making |
| Self breast exam | Sexually transmitted diseases |
| Self testicular exam | Unintended pregnancy |
| Sexual abuse, date rape | |
| ***Health Consumer Issues*** | |
| Selection and purchase of health devices or items | Selection and utilization of health services |
| ***Injury Prevention*** | |
| ATV safety | Over exposure to sun |
| CPR and first aid training | ROPS(roll over protective structure) |
| Dangers of farm ponds and creeks | Seat belt usage |
| Falls | Smoke detector |
| Firearm safety, hunting practices | Sports recreation, workshop laboratory, job, or home injury prevention |
| Gun and hunter safety | |
| Handling agricultural chemicals | Tanning practices |
| Hearing conservation | Violent behavior |
| Machinery safety | Water safety |
| Motorized vehicle safety (ATV, moped, motorcycle, car, and trucks) | |
| ***Nutrition*** | |
| Body image, weight issues | Food fads, snacks, fast foods |
| Caloric requirements by age and gender | Selection of fitness program by need, age, and gender |
| Diet to meet needs of growth | |
| Exercise, sports, and fitness | Special diets |

| | |
|---|---|
| ***Relationships and Behavior*** | |
| Communication skills | Relationships with adults and peers |
| Dating relationships | Self esteem building |
| Decision making | Stress management and reduction |
| ***Substance Use*** | |
| Alcohol/drug cessation | Riding with intoxicated driver |
| Counseling/referral for chemical abuse | Sharing of drug paraphernalia |
| Driving under the influence | Steroid or steroid-like use |
| HIV counseling/referral | Tobacco cessation |

## B. Physical Examination

Perform a comprehensive unclothed physical examination at each screening visit. It should include, but is not limited to, the following:

- General appearance.
- Assessment of all body systems.
- Height and weight.
- Head circumference through 2 years of age.
- Blood pressure starting at 3 years of age.
- Palpation of femoral and brachial (or radial) pulses.
- Breast inspection and palpation for age-appropriate females, including breast self-examination instructions and health education.
- Pelvic examination, recommended for women 18 years old and older, if sexually active, or significant menstrual problems.
- Testicular examination, include age-appropriate self-examination instructions and health education.

## 1. Growth Measurements

### a. Recumbent Length

Measure the length of infants and children up to two years of age on a horizontal length board with a fixed headboard and sliding footboard securely attached at right angles to the measuring surface. Read and record the measurement to the nearest 1/8th inch.

### b. Height

Measure children over 2 years of age using a standing height board or stadiometer.

If the child is two years old or older and less than 31 1/2 inches tall, the height measurement does not fit on the 2-20 year old chart. Therefore you must measure the child's recumbent length and plot the length on the Birth-36 month growth chart. Read and record the measurement to the nearest 1/8th inch.

Never use measuring rods attached to scales, because the surface on which the child stands is not stable, and the measuring rod's hinge tends to become loose, causing inaccurate readings.

### c. Weight

Use a balance beam scale with non-detachable weights. Calibrate the scale once a year. Infants can be measured on either a specially designed infant scale or in a cradle on the adult scale.

Weigh infants and children with a minimal amount of clothing. Read and record to the nearest ounce for infants and quarter of a pound for children and youth.

**d. Body Mass Index**

Body mass index (BMI) is the recommended parameter for monitoring the growth of children 24 months and older. BMI can be determined using a handheld calculator. The steps for calculating BMI using pounds and inches are listed below.

1. Convert any fractions to decimals.
   Examples: 37 pounds 4 ounces = 37.25 pounds
   41 ½ inches = 41.5 inches

2. Insert the values into the formula:
   - [weight (1b) / height (in) / height (in)] X 703 = BMI
     Example: (37.25 lb / 41.5 in / 41.5 in) X 703 = 15.2

A reference table for calculating BMI can be downloaded from the Centers for Disease Control and Prevention web site at **www.cdc.gov/growthcharts**.

For children, BMI values are plotted against age. If the BMI-for-age is less than or equal to the 5$^{th}$ percentile, the child is considered underweight. If the BMI-for-age is between the 85$^{th}$ and 94$^{th}$ percentiles, the child is considered to be at risk for overweight. Children with a BMI equal to or greater than the 95$^{th}$ percentile are considered to be overweight.

**e. Plotting Measurements**

Record measurements as soon as they are taken to reduce errors.

Plot weight and height against age and weight against height on the Center for Disease Control and Prevention (CDC) growth chart for the children under 2 years of age. For children 2-20 years, plot weight and height against age and BMI against age on the appropriate growth chart.

| | Year | | Month | | | Day | | |
|---|---|---|---|---|---|---|---|---|
| Date of visit | ~~93~~ | 92 | ~~7~~ | ~~6~~ | 18 | ~~15~~ | 45 | July 15, 1993 |
| Birth date | -91 | | -10 | | | -28 | | October 28, 1991 |
| Age | 1 | | 8 | | | 17 | | = 20 months, 17 days or 21 months |

Borrow 30 days for the 7 in the month column to make the day column 45 and the month column 6.

Borrow 12 months for 93 in the year column so that the top number in the month column is now 18.

Calculate the age to the nearest month. (Round to the next month if over 15 days.) Subtract birth date from the clinic visit date. You may borrow 30 days from the months column or 12 months for the year column when subtracting.

Common errors result from unbalanced scales, failure to remove shoes and heavy clothing, use of an inappropriate chart for recording the results, and uncooperative children.

**f. Referral and Follow-up of Growth in Infants and Children**

Nutrition referrals: See criteria in **IX.D.2. Nutritional Status**.

Medical referrals: Most children follow the usual patterns of growth, but a small but significant number of children have growth patterns that cross percentile lines in infancy, familial short stature, constitutional growth delay, and familial tall stature. Some warning signs of growth abnormalities are as follows:

- Growth of less than 2 inches/year for ages 3 to 10 years.
- A 25 percentile greater change in weight/height percentile rank.
- Sudden weight gain or loss.
- More than 2 standard deviations below or above the mean for height.

Page 151 is reserved for future use.

Page 152 is reserved for future use.

**2. Head Circumference**

Measure the head circumference at each visit until the child is two years old. Measure with a nonstretchable tape measure firmly placed from the maximal occipital prominence around to the area just above the eyebrow. Plot the results on the Center for Disease & Prevention (CDC) growth chart.

Further evaluation is needed if the CDC growth grid reveals a measurement:

- Above the 95th percentile.
- Below 5th percentile.
- Reflecting a major change in percentile levels from one measurement to the next or over time.

**3. Blood Pressure**

Blood pressure measurement is a routine part of the physical examination at three years of age and older. During infancy, do a blood pressure only if other physical findings suggest it may be needed.

Recently the National Health, Lung and Blood Institute published new blood pressure standards for children and adolescents. The new standards are based on height as well as age and gender for children and adolescents from one through seventeen years old.

This is a change from the past when height and weight were both thought to be correlates of blood pressure. Height was determined by the investigators to be a better correlate for children and teenagers because of the prevalence of obesity in young people in this country. The standards appear in Tables 1 and 2.

**a. Use of Blood Pressure Tables in a Clinical Setting**

To use the new tables, you need to measure each child and plot the height on a standard growth chart. Measure the child's systolic and diastolic blood pressure and compare them to the numbers provided in the tables for blood pressure for height, age and sex.

The National Heart, Lung and Blood Institute recommends to using the disappearance of Korotkoff's (K5) to determine diastolic blood pressure in children and adolescents.

**b. Interpretation of Blood Pressure Readings**

The interpretation of children and adolescents blood pressure measurements for height, age and gender are as follows:

- Readings below the 90th percentile are considered normotensive.
- Reading between the 90th and 95th percentile are high-normal and warrant further observation and identification of risk factors.
- Readings of either systolic or diastolic at or above the 95th percentiles indicate the child may be hypertensive. Repeated measurements are indicated.

## Table 1. Blood Pressure Levels for Boys Aged 1 to 17 Years by Percentile of Height

| Boys | | Systolic BP (mm Hg) by percentile of height* | | | | | | | Diastolic BP (mm Hg) by percentile of height* | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Age** | **Percentile** | **5%** | **10%** | **25%** | **50%** | **75%** | **90%** | **95%** | **5%** | **10%** | **25%** | **50%** | **75%** | **90%** | **95%** |
| **1 yr** | 90th | 94 | 95 | 97 | 98 | 100 | 102 | 102 | 50 | 51 | 52 | 53 | 54 | 54 | 55 |
| | 95th | 98 | 99 | 101 | 102 | 104 | 106 | 106 | 55 | 55 | 56 | 57 | 58 | 59 | 59 |
| **2 yr** | 90th | 98 | 99 | 100 | 102 | 104 | 105 | 106 | 55 | 55 | 56 | 57 | 58 | 59 | 59 |
| | 95th | 101 | 102 | 104 | 106 | 108 | 109 | 110 | 59 | 59 | 60 | 61 | 62 | 63 | 63 |
| **3 yr** | 90th | 100 | 101 | 103 | 105 | 107 | 108 | 109 | 59 | 59 | 60 | 61 | 62 | 63 | 63 |
| | 95th | 104 | 105 | 107 | 109 | 111 | 112 | 113 | 63 | 63 | 64 | 65 | 66 | 67 | 67 |
| **4 yr** | 90th | 102 | 103 | 105 | 107 | 109 | 110 | 111 | 62 | 62 | 63 | 64 | 65 | 66 | 66 |
| | 95th | 106 | 107 | 109 | 111 | 113 | 114 | 115 | 66 | 67 | 67 | 68 | 69 | 70 | 71 |
| **5 yr** | 90th | 104 | 105 | 106 | 108 | 110 | 112 | 112 | 65 | 65 | 66 | 67 | 68 | 69 | 69 |
| | 95th | 108 | 109 | 110 | 112 | 114 | 115 | 116 | 69 | 70 | 70 | 71 | 72 | 73 | 74 |
| **6 yr** | 90th | 105 | 106 | 108 | 110 | 111 | 113 | 114 | 67 | 68 | 69 | 70 | 70 | 71 | 72 |
| | 95th | 109 | 110 | 112 | 114 | 115 | 117 | 117 | 72 | 72 | 73 | 74 | 75 | 76 | 76 |
| **7 yr** | 90th | 106 | 107 | 109 | 111 | 113 | 114 | 115 | 69 | 70 | 71 | 72 | 72 | 73 | 74 |
| | 95th | 110 | 111 | 113 | 115 | 116 | 118 | 119 | 74 | 74 | 75 | 76 | 77 | 78 | 78 |
| **8 yr** | 90th | 107 | 108 | 110 | 112 | 114 | 115 | 116 | 71 | 71 | 72 | 73 | 74 | 75 | 75 |
| | 95th | 111 | 112 | 114 | 116 | 118 | 119 | 120 | 75 | 76 | 76 | 77 | 78 | 79 | 80 |
| **9 yr** | 90th | 109 | 110 | 112 | 113 | 115 | 117 | 117 | 72 | 73 | 73 | 74 | 75 | 76 | 77 |
| | 95th | 113 | 114 | 116 | 117 | 119 | 121 | 121 | 76 | 77 | 78 | 79 | 80 | 80 | 81 |
| **10 yr** | 90th | 110 | 112 | 113 | 115 | 117 | 118 | 119 | 73 | 74 | 74 | 75 | 76 | 77 | 78 |
| | 95th | 114 | 115 | 117 | 119 | 121 | 122 | 123 | 77 | 78 | 79 | 80 | 80 | 81 | 82 |
| **11 yr** | 90th | 112 | 113 | 115 | 117 | 119 | 120 | 121 | 74 | 74 | 75 | 76 | 77 | 78 | 78 |
| | 95th | 116 | 117 | 119 | 121 | 123 | 124 | 125 | 78 | 79 | 79 | 80 | 81 | 82 | 83 |
| **12 yr** | 90th | 115 | 116 | 117 | 119 | 121 | 123 | 123 | 75 | 75 | 76 | 77 | 78 | 78 | 79 |
| | 95th | 119 | 120 | 121 | 123 | 125 | 126 | 127 | 79 | 79 | 80 | 81 | 82 | 83 | 83 |
| **13 yr** | 90th | 117 | 118 | 120 | 122 | 124 | 125 | 126 | 75 | 76 | 76 | 77 | 78 | 79 | 80 |
| | 95th | 121 | 122 | 124 | 126 | 128 | 129 | 130 | 79 | 80 | 81 | 82 | 83 | 83 | 84 |
| **14 yr** | 90th | 120 | 121 | 123 | 125 | 126 | 128 | 128 | 76 | 76 | 77 | 78 | 79 | 80 | 80 |
| | 95th | 124 | 125 | 127 | 128 | 130 | 132 | 132 | 80 | 81 | 81 | 82 | 83 | 84 | 85 |
| **15 yr** | 90h | 123 | 124 | 125 | 127 | 129 | 131 | 131 | 77 | 77 | 78 | 79 | 80 | 81 | 81 |
| | 95th | 127 | 128 | 129 | 131 | 133 | 134 | 135 | 81 | 82 | 83 | 83 | 84 | 85 | 86 |
| **16 yr** | 90th | 125 | 126 | 128 | 130 | 132 | 133 | 134 | 79 | 79 | 80 | 81 | 82 | 82 | 83 |
| | 95th | 129 | 130 | 132 | 134 | 136 | 137 | 138 | 83 | 83 | 84 | 85 | 86 | 87 | 87 |
| **17 yr** | 90th | 128 | 129 | 131 | 133 | 134 | 136 | 136 | 81 | 81 | 82 | 83 | 84 | 85 | 85 |
| | 95th | 132 | 133 | 135 | 136 | 138 | 140 | 140 | 85 | 85 | 86 | 87 | 88 | 89 | 89 |

*Height percentile determined by standard growth curves. Diastolic BP determined by disappearance of Korokoff's sounds (K5), Source: National Heart, Lung and Blood Institute: Update on the 1997 Task Force Report on High Blood Pressure in Children and Adolescents, A Working Group Report from the National High Blood Pressure Education Program, Pediatrics Vol. 98 No.4 October 1996.

## Table II. Blood Pressure Levels for Girls Aged 1 to 17 Years by Percentile of Height

| GIRLS | | Systolic BP (mm Hg) by percentile of height* | | | | | | | Diastolic BP (mm Hg) by percentile of height* | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Age** | **Percentile** | **5%** | **10%** | **25%** | **50%** | **75%** | **90%** | **95%** | **5%** | **10%** | **25%** | **50%** | **75%** | **90%** | **95%** |
| **1 yr** | 90th | 97 | 98 | 99 | 100 | 102 | 103 | 104 | 53 | 53 | 53 | 54 | 55 | 56 | 56 |
| | 95th | 101 | 102 | 103 | 104 | 105 | 107 | 107 | 57 | 57 | 57 | 58 | 59 | 60 | 60 |
| **2 yr** | 90th | 99 | 99 | 100 | 102 | 103 | 104 | 105 | 57 | 57 | 58 | 58 | 59 | 60 | 61 |
| | 95th | 102 | 103 | 104 | 105 | 107 | 108 | 109 | 61 | 61 | 62 | 62 | 63 | 64 | 65 |
| **3 yr** | 90th | 100 | 100 | 102 | 103 | 104 | 105 | 106 | 61 | 61 | 61 | 62 | 63 | 63 | 64 |
| | 95th | 104 | 104 | 105 | 107 | 108 | 109 | 110 | 65 | 65 | 65 | 66 | 67 | 67 | 68 |
| **4 yr** | 90th | 101 | 102 | 103 | 104 | 106 | 107 | 108 | 63 | 63 | 64 | 65 | 65 | 66 | 67 |
| | 95th | 105 | 106 | 107 | 108 | 109 | 111 | 111 | 67 | 67 | 68 | 69 | 69 | 70 | 71 |
| **5 yr** | 90th | 103 | 103 | 104 | 106 | 107 | 108 | 109 | 65 | 66 | 66 | 67 | 68 | 68 | 69 |
| | 95th | 107 | 107 | 108 | 110 | 111 | 112 | 113 | 69 | 70 | 70 | 71 | 72 | 72 | 73 |
| **6 yr** | 90th | 104 | 105 | 106 | 107 | 109 | 110 | 111 | 67 | 67 | 68 | 69 | 69 | 70 | 71 |
| | 95th | 108 | 109 | 110 | 111 | 112 | 114 | 114 | 71 | 71 | 72 | 73 | 73 | 74 | 75 |
| **7 yr** | 90th | 106 | 107 | 108 | 109 | 110 | 112 | 112 | 69 | 69 | 69 | 70 | 71 | 72 | 72 |
| | 95th | 110 | 110 | 112 | 113 | 114 | 115 | 116 | 73 | 73 | 73 | 74 | 75 | 76 | 76 |
| **8 yr** | 90th | 108 | 109 | 110 | 111 | 112 | 113 | 114 | 70 | 70 | 71 | 71 | 72 | 73 | 74 |
| | 95th | 112 | 112 | 113 | 115 | 116 | 117 | 118 | 74 | 74 | 75 | 75 | 76 | 77 | 78 |
| **9 yr** | 90th | 110 | 110 | 112 | 113 | 114 | 115 | 116 | 71 | 72 | 72 | 73 | 74 | 74 | 75 |
| | 95th | 114 | 114 | 115 | 117 | 118 | 119 | 120 | 75 | 76 | 76 | 77 | 78 | 78 | 79 |
| **10 yr** | 90th | 112 | 112 | 114 | 115 | 116 | 117 | 118 | 73 | 73 | 73 | 74 | 75 | 76 | 76 |
| | 95th | 116 | 116 | 117 | 119 | 120 | 121 | 122 | 77 | 77 | 77 | 78 | 79 | 80 | 80 |
| **11 yr** | 90th | 114 | 114 | 116 | 117 | 118 | 119 | 120 | 74 | 74 | 75 | 75 | 76 | 77 | 77 |
| | 95th | 118 | 118 | 119 | 121 | 122 | 123 | 124 | 78 | 78 | 79 | 79 | 80 | 81 | 81 |
| **12 yr** | 90th | 116 | 116 | 118 | 119 | 120 | 121 | 122 | 75 | 75 | 76 | 76 | 77 | 78 | 78 |
| | 95th | 120 | 120 | 121 | 123 | 124 | 125 | 126 | 79 | 79 | 80 | 80 | 81 | 82 | 82 |
| **13 yr** | 90th | 118 | 118 | 119 | 121 | 122 | 123 | 124 | 76 | 76 | 77 | 78 | 78 | 79 | 80 |
| | 95th | 121 | 122 | 123 | 125 | 126 | 127 | 128 | 80 | 80 | 81 | 82 | 82 | 83 | 84 |
| **14 yr** | 90th | 119 | 120 | 121 | 122 | 124 | 125 | 126 | 77 | 77 | 78 | 79 | 79 | 80 | 81 |
| | 95th | 123 | 124 | 125 | 126 | 128 | 129 | 130 | 81 | 81 | 82 | 83 | 83 | 84 | 85 |
| **15 yr** | 90h | 121 | 121 | 122 | 124 | 125 | 126 | 127 | 78 | 78 | 79 | 79 | 80 | 81 | 82 |
| | 95th | 124 | 125 | 126 | 128 | 129 | 130 | 131 | 82 | 82 | 83 | 83 | 84 | 85 | 86 |
| **16 yr** | 90th | 122 | 122 | 123 | 125 | 126 | 127 | 128 | 79 | 79 | 79 | 80 | 81 | 82 | 82 |
| | 95th | 125 | 126 | 127 | 128 | 130 | 131 | 132 | 83 | 83 | 83 | 84 | 85 | 86 | 86 |
| **17 yr** | 90th | 122 | 123 | 124 | 125 | 126 | 128 | 128 | 79 | 79 | 79 | 80 | 81 | 82 | 82 |
| | 95th | 126 | 126 | 127 | 129 | 130 | 131 | 132 | 83 | 83 | 83 | 84 | 85 | 86 | 86 |

*Height percentile determined by standard growth curves. Diastolic BP determined by disappearance of Korokoff's sounds (K5), Source: National Heart, Lung and Blood Institute: Update on the 1997 Task Force Report on High Blood Pressure in Children and Adolescents, A Working Group Report from the National High Blood Pressure Education Program, Pediatrics Vol. 98 No.4 October 1996.

### 4. Oral Health Screening

The purpose of the oral health screening is to identify dental anomalies or diseases, such as dental caries (decay), soft tissue lesions, gum disease, or developmental problems and to ensure that preventive dental education is provided to the parents or guardians.

Unlike other health needs, dental problems are so prevalent that most children over 12 months will need diagnostic evaluation and treatment. The oral health screening should include all of the following and should be documented in the child's record:

- Complete or update the dental history:
  - Current or recent dental problems, including pain or injuries to the mouth
  - Name of dentist
  - Date of child's last dental visit or length of time since last dental visit
- Assess risk factors for dental caries:
  - History of previous decay
  - Stained fissures on primary teeth
  - White spot lesions
  - Visible plaque
- Make a visual or tactile inspection of the oral cavity that includes:
  - Teeth
    - Number of teeth
    - Tooth eruption pattern
    - Dental caries
    - Missing or broken teeth
    - Malocclusion
    - Oral hygiene status
  - Soft tissue
    - Inflamed or swollen gums
    - Lesions on tongue, cheeks, or gums
- Provide age-appropriate oral health education to parent or guardian. Education should be based on the findings of the oral health screening.

- Refer children to a dentist for:
  - Complete dental examination annually starting at 12 months and semiannually starting at 24 months, unless a dentist recommends more frequent visits;
  - Obvious or suspected dental caries;
  - Pain or injury to the oral tissue; and
  - Difficulty chewing

## C. Laboratory Tests

### 1. Hemoglobin and Hematocrit

The American Academy of Pediatrics suggests one hematocrit or hemoglobin determination during the first year, and at each of the following intervals:

- 9-12 months, if any of the following risk factors are present:
  - Qualify for EPSDT Care for Kids
  - Low socioeconomic status
  - Birth weight under 1500 grams
  - Whole milk given before 6 months of age (not recommended)
  - Low-iron formula given (not recommended)
- 11-20 years. Annual screening for females, if any of the following factors are present:
  - Qualify for EPSDT Care for Kids
  - Moderate to heavy menses
  - Chronic weight loss
  - Nutrition deficit
  - Athletic activity

A test for anemia may be performed at any age if there is:

- Medical indication noted in the physical examination
- Nutritional history of inadequate iron in the diet
- History of blood loss
- Family history of anemia

All children whose hemoglobin or hematocrit is less than the fifth percentile are considered at risk for developing anemia.

Children under five years of age with incomes under 185% of poverty and hemoglobins or hematocrit below the fifth percentile qualify for the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

**Fifth Percentile Criteria for Children**

| Age/Years | Hematocrit | Hemoglobin |
|---|---|---|
| 6 months up to 2 years | 32.9 | 11.0 |
| 2 up to 5 years | 33.0 | 11.1 |
| 5 up to 8 years | 34.5 | 11.5 |
| 8 up to 12 years | 35.4 | 11.9 |
| **Female** (nonpregnant) | | |
| 12 up to 15 years | 35.5 | 11.8 |
| 15 up to 18 years | 35.9 | 12.0 |
| 18 up to 21 years | 35.7 | 12.0 |
| **Male** | | |
| 12 up to 15 years | 37.3 | 12.5 |
| 15 up to 18 years | 39.7 | 13.3 |
| 18 up to 21 years | 39.9 | 13.5 |

Source: "Recommendations to Prevent and Control Iron Deficiency in the United States," Morbidity and Mortality Weekly Report April 3, 1998; Vol. 47, No. RR-3, pages 1-29.

**2. Urinalysis**

Depending on the success in obtaining a voided urine specimen, urinalysis is suggested:

- At 5 years
- Once from 11 through 20 years, preferably at 14 years

Use a dipstick that shows at least pH, glucose, protein, blood, and nitrates. Referral criteria should include:

- PH below 5 or above 9
- Glycosuria
- 2+ protein
- Positive nitrates
- Trace or greater blood

**3. Metabolic Screening**

Confirm during the infant's first visit that newborn screening was done. In Iowa newborn screening is mandatory for the following conditions:

- Congenital adrenal hyperplasia
- Galactosemia
- Hemoglobinopathies
- Hypothyroidism
- Phenylketonuria (PKU)
- Medium chain acyl Co-A dehydrogenase (MCAD) deficiency
- Biotinidase deficiency

**4. Hemoglobinopathy Screening**

Screen infants not born in Iowa for hemoglobin disorders. Screen children who were born before February 1988, if they are at risk for hemoglobin disorders (those of Caribbean, Latin American, Asian, Mediterranean, and African descent). Identification of carrier status before conception permits genetic counseling and availability of diagnostic testing in the event of pregnancy.

The Hemoglobinopathy Screening and Comprehensive Care Program at the University of Iowa offers testing for a small fee. Call 319-356-1400 for information.

### 5. Tuberculin Testing

The American Academy of Pediatrics Committee on Infectious Disease recommends annual tuberculin testing in high-risk children.

Do the Mantoux skin test on household members of persons for whom tuberculosis is common (e.g., from Asia, Africa, Central America, the Pacific Islands, Caribbean; migrant workers; residents of correctional institutions and homeless shelters; and children in the homes of IV drug users, alcoholics, HIV positives, and prostitutes).

### 6. Lead Testing

Perform blood lead testing for lead toxicity on children aged 12 to 72 months of age. The goal of all lead poisoning prevention activities is to reduce children's blood lead levels below 10 µg/dL.

Do not use erythrocyte protoporphyrin (EP) as a screening tool for lead poisoning, because it is not sensitive enough to identify children with blood lead levels below 25 µg/dL.

Initial screening may be done using a capillary specimen if procedures are followed to prevent the contamination of the sample. Consider an elevated blood level from a capillary test presumptive. Confirm it with a venous blood specimen.

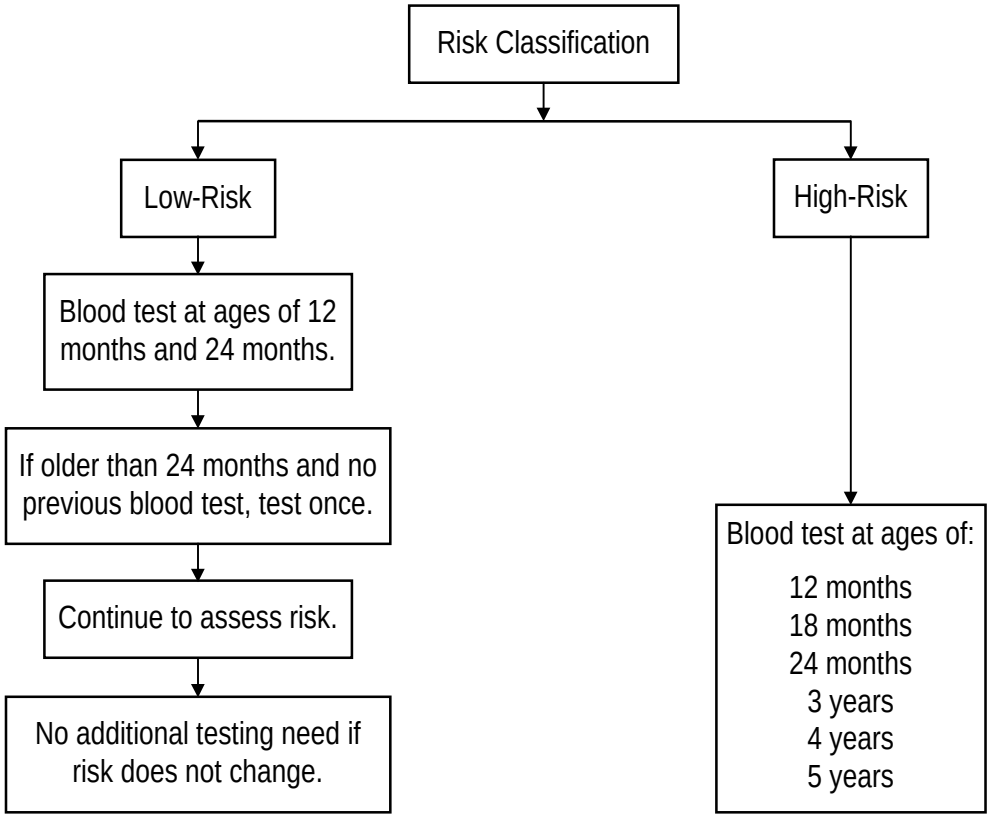
#### a. Determining Risk Through Asking Questions

Beginning with the age of 12 months, ask the following questions for all children at each office visit to determine each child's risk for lead poisoning:

- Has your child ever lived in or regularly visited a house built before 1960? (Examples: home, child care center, baby-sitter, relatives' home)
- Have you noticed any peeling or chipping paint in or around the pre-1960 house that your child lives in or regularly visits?

- Is the pre-1960 home that your child lives in or regularly visits being remodeled or renovated by:
  - Stripping, sanding, or scraping paint on the inside or outside of the house?
  - Removing walls or tearing out lath and plaster?
- Does your child eat non-food items, such as dirt?
- Have any of your other children or their playmates had elevated lead levels ≥ 15 µg/dL?
- Does your child live with or frequently come in contact with an adult who works with lead on the job or in a hobby? (Examples: painter, welder, foundry worker, old home renovator, shooting range worker, battery plant worker, battery recycling worker, ceramic worker, stained glass worker, sheet metal worker, plumber.)
- Does your child live near a battery plant, battery recycling plant, or lead smelter?
- Do you give your child any home or folk remedies? (Examples: Azarcon, Greta, Pay-loo-ah)
- Does your child eat candy that comes from Mexico or is purchased from a Mexican grocery store?
- Has you child ever lived in Mexico, Central America, or South America or visited one of these areas for a period longer than two months?
- If the answer to **any** of these questions is yes, the child is considered to be at high risk for lead poisoning and needs to be screened according to the high-risk screening schedule.

**b. Basic Lead Testing Chart (Based on Risk and Age)**




NOTE: If you see children at different ages than these, you can change these schedules to correspond with the ages when you do see children.

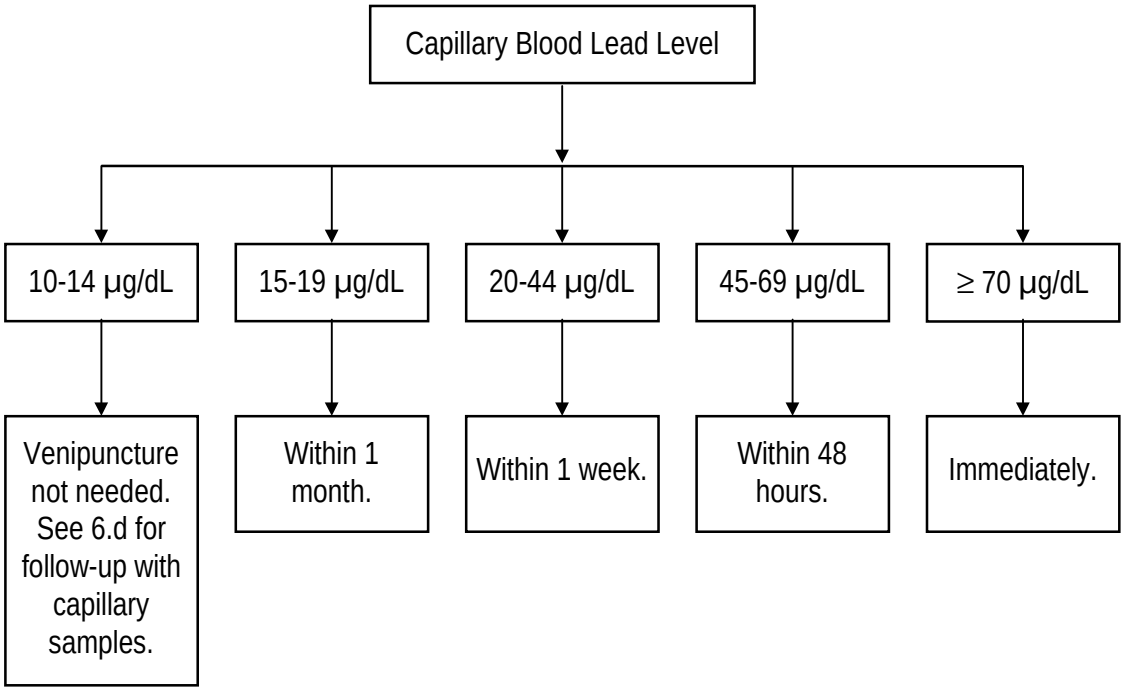
If capillary samples are used, see next page for follow-up of any level ≥ 10 µg/dL.

If venous samples are used, see Sections 6.d, 6.e, and 6.f for follow-up of any level ≥10 µg/dL.

Source: Center for Disease Control (CDC), *Preventing Lead Poisoning in Young Children* (Revised 12/97).

**c. Schedule for Obtaining Confirmatory Venipunctures**

Children who have blood lead levels ≥ 15 µg/dL on a capillary sample should have these levels confirmed on venous samples according to the timetables below.




If venous level < 9 µg/dL, return to regular blood lead testing schedule.

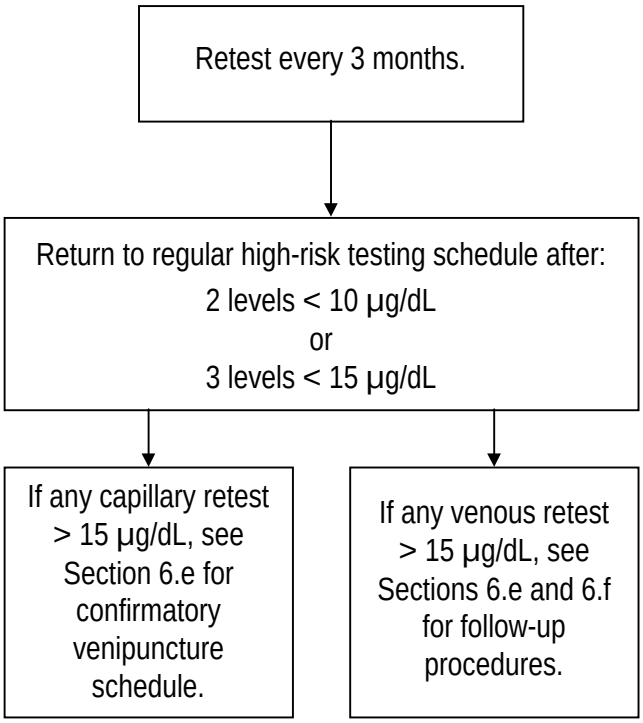
If venous level 10-14 µg/dL, see Section 6.d.

If venous level 15-19 µg/dL, see Section 6.e.

If venous level ≥ 20 µg/dL, see Section 6.f.

Source: Center for Disease Control (CDC), *Preventing Lead Poisoning in Young Children* (Revised 12/97).

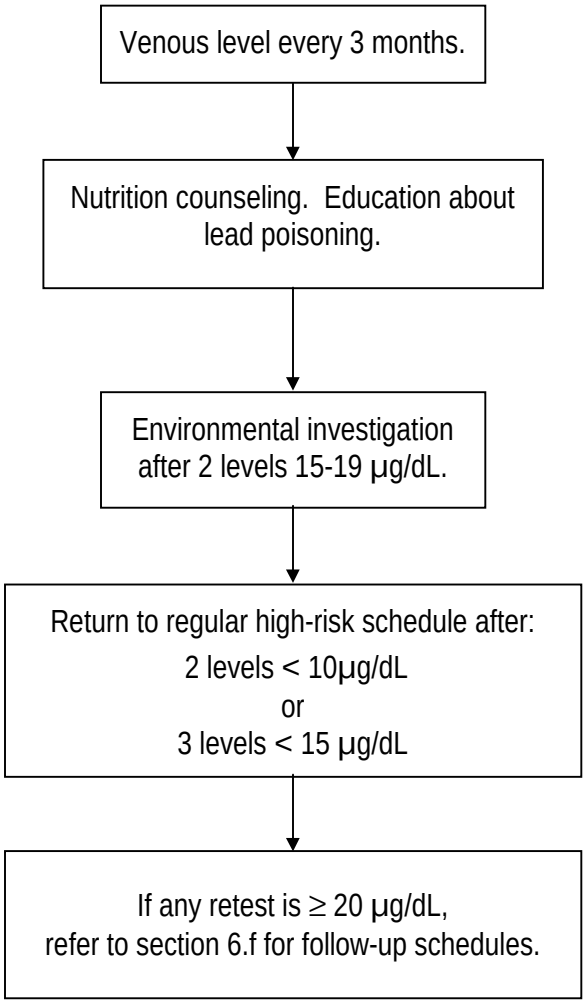
**d. Follow-up of Elevated Blood Lead Levels (10-14 µg/dL)**




Source: Center for Disease Control (CDC), *Preventing Lead Poisoning in Young Children* (Revised 12/93).

**e. Follow-up of Elevated Venous Blood Leads (15-19 µg/dL)**

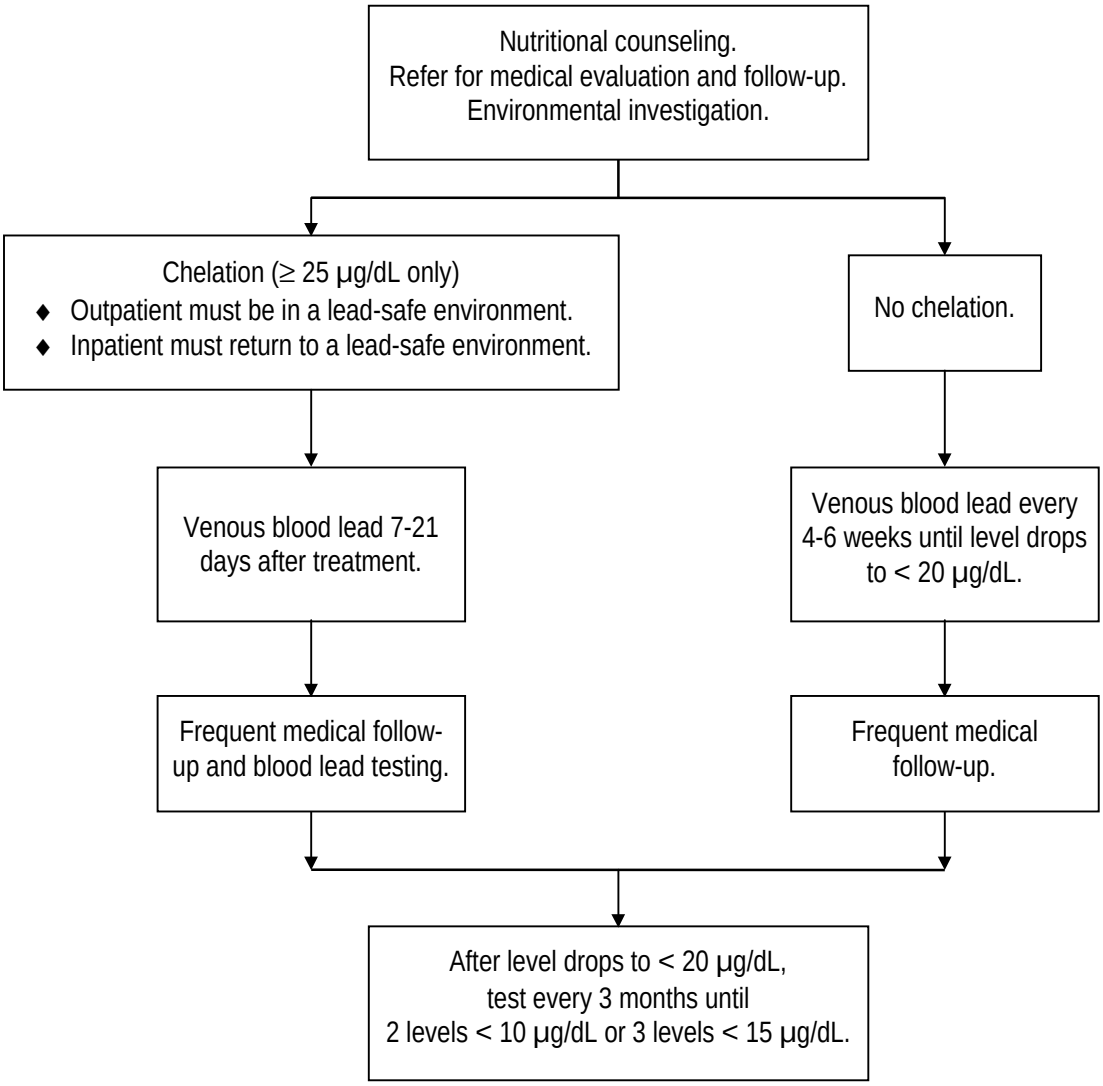
All children who have had venous levels ≥ 15 µg/dL are considered "high" risk regardless of initial risk assessment.




See Sections 6.g and 6.h for time frames for referrals.

Source: Center for Disease Control (CDC), *Preventing Lead Poisoning in Young Children* (Revised 12/93).

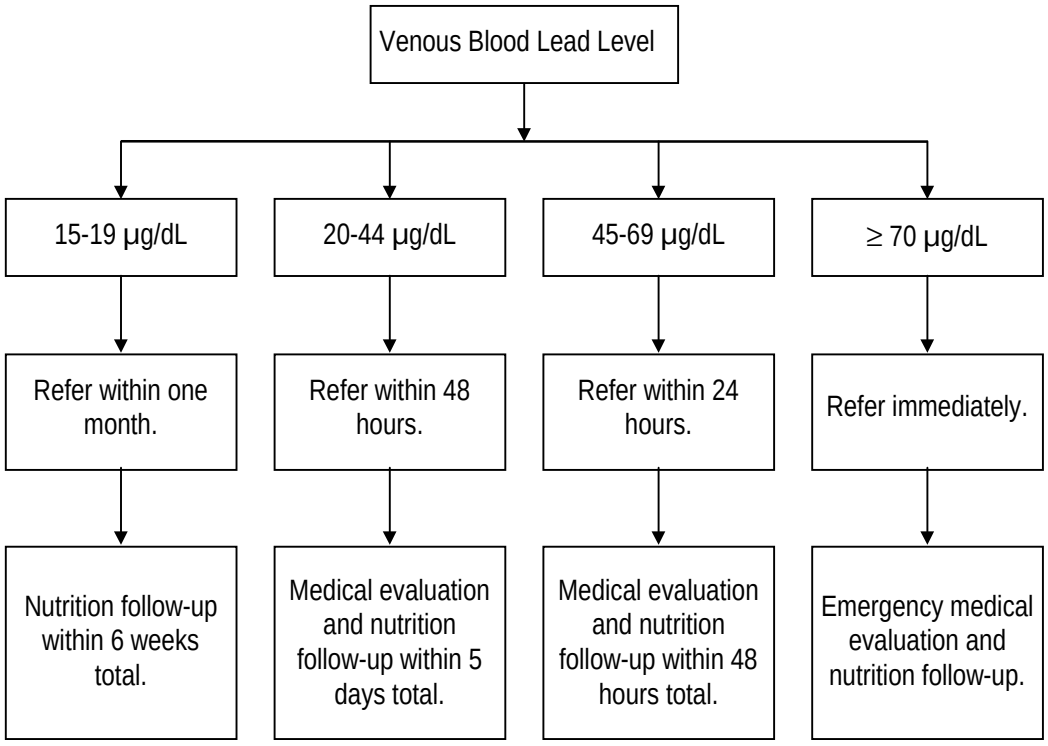
### f. Follow-up of Elevated Venous Levels (≥ 20 µg/dL)




See Sections 6.g and 6.h for time frames for referrals.

Source: Center for Disease Control (CDC), *Preventing Lead Poisoning in Young Children* (Revised 12/93).

**g. Timelines for Medical and Nutritional Follow-up**

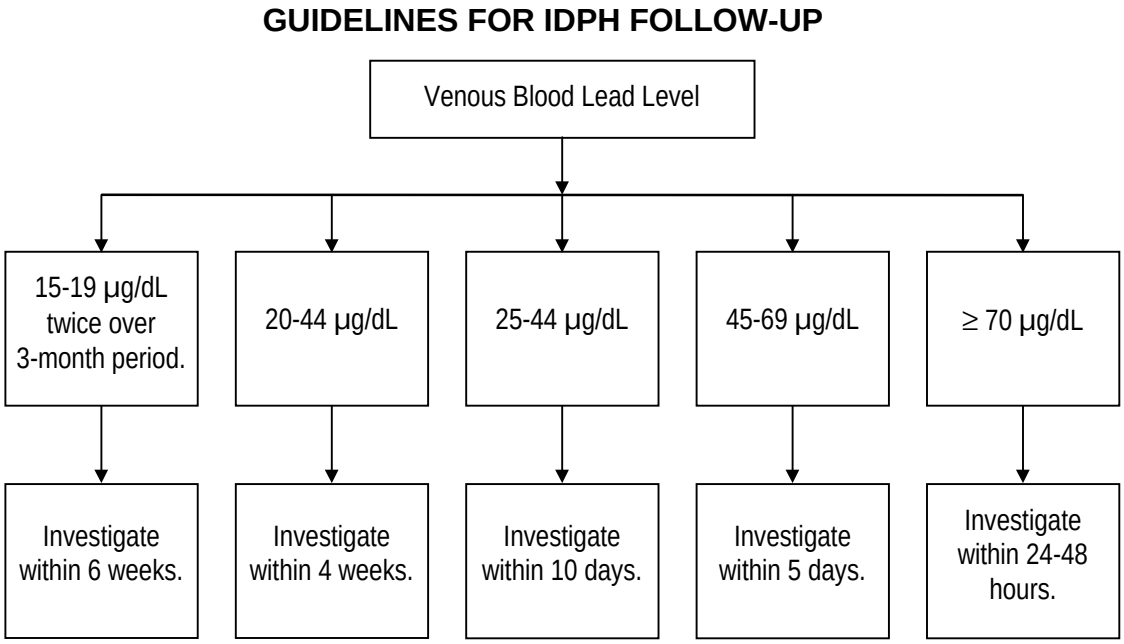



Source: Center for Disease Control (CDC), *Preventing Lead Poisoning in Young Children* (Revised 12/93).

Nutrition information can be obtained by contacting Susan Pohl, Licensed Dietitian, Iowa Department of Public Health at 515/281-4545

Medical management information can be obtained by contacting the Medical Director of Family and Community Health, Iowa Department of Public Health at 515/281-4912.

**h. Timelines for Environmental Follow-up**




Source: Center for Disease Control (CDC), *Preventing Lead Poisoning in Young Children* (Revised 12/93).

**i. Resource Persons for Lead Testing, Screening, and Case Management**

Ken Choquette, Coordinator of Lead Prevention Program, Iowa Department of Public Health, 515-281-8220 or 1-800-972-2026.

Rita Gergely, Environmental Specialist, Iowa Department of Public Health, 515-281-6340 or 1-800-972-2026.

### 7. Cervical Papanicolaou (PAP) Smear

Regular cervical Papanicolaou (PAP) smears are recommended for all females who are sexually active or if the sexual history is thought to be unreliable at age 18 years. High-risk individuals for cancer in situ are those who:

- Begin sexual activity in early teen years, and
- Have multiple partners.

Sexually active females should receive family planning counseling, including pap smears, self breast examinations, and education on prevention of sexually transmitted diseases.

Make a referral for further evaluation, diagnosis, or treatment when the smear demonstrates an abnormality. If first smear is unsatisfactory, repeat as soon as possible.

### 8. Gonorrhea Test

Testing for gonorrhea may be done on persons with:

- Multiple sexual partners or a sexual partner with multiple contacts.
- Sexual contacts with a person with culture-proven gonorrhea.
- A history of repeated episodes of gonorrhea.
- Discuss how to use contraceptives and make them available.
- Education on prevention of sexually transmitted diseases.

### 9. Chlamydia Test

Routine testing of sexually active women for chlamydia trachomatis is recommended for asymptomatic persons at high risk for infection (e.g., age less than 25, multiple sexual partners with multiple sexual contacts). For recent sexual partners of persons with positive tests for STD, also provide:

- Education on prevention of sexually transmitted diseases.
- Education on the importance of contraception to prevent pregnancy.

## D. Other Services

Other services that must be included in the screening examination are:

- Immunizations
- Assessment of nutritional status
- Vision screening
- Hearing screening

### 1. Immunization

In an effort to improve immunization practice, the health objectives for the nation call for a minimum of 90% of children to have recommended immunizations by their second birthday.

Standards published by the National Vaccine Advisory Committee in May 1992 clarify factors which limit the provision of immunizations. The standards address access to immunizations, education concerning contraindications, practice management activities, and tracking systems.

Every time children are seen, screen their immunization status and administer appropriate vaccines. (See **Item b**.) You can obtain information about immunizations by contacting 1-800-831-6293.

Many opportunities to immunize children are missed due to lack of knowledge about true contraindications, such as erroneously considering mild illness a contraindication. See **Item c** for a guide to contraindications to immunization.

When multiple vaccines are needed, administer vaccines simultaneously to decrease the number of children lost to follow-up. Do this particularly in high-risk populations who tend to be transient and noncompliant with recommendations for routine health maintenance visits.

**a. Standards for Pediatric Immunization Practices**

Standard 1. Immunization services are **readily available**.

Standard 2. There are **no barriers** or **unnecessary prerequisites** to the receipt of vaccines.

Standard 3. Immunization services are available free or for a minimal **fee**.

Standard 4. Providers utilize all clinical encounters to **screen** and, when indicated, immunize children.

Standard 5. Providers **educate** parents and guardians about immunization in general terms.

Standard 6. Providers **question** parents or guardians about **contraindications** and, before immunizing the child, **inform** them in specific terms about the risks and benefits of immunizations their child is to receive.

Standard 7. Providers follow only true **contraindications**.

Standard 8. Providers administer **simultaneously** all vaccine doses for which a child is eligible at the time of each visit.

Standard 9. Providers use accurate and complete recording procedures.

Standard 10. Providers **co-schedule** immunization appointments in conjunction with appointments for other child health services.

Standard 11. Providers **report adverse events** following immunization promptly, accurately, and completely.

Standard 12. Providers operate a **tracking system**.

Standard 13. Providers adhere to appropriate procedures for vaccine management.

Standard 14. Providers conduct semiannual **audits** to assess immunization coverage levels and to review immunization records in the patient populations they serve.

Standard 15. Providers maintain up-to-date, easily retrievable **medical protocols** at all locations where vaccines are administered.

Standard 16. Providers operate with **patient-oriented** and community-based approaches.

Standard 17. Vaccines are administered by **properly trained** individuals.

Standard 18. Providers receive **ongoing education** and **training** on current immunization recommendations.

This information is excerpted from *Standards for Pediatric Immunization Practices*, issued May 11, 1992, by the U.S. Department of Health and Human Services, Public Health Service.

**b. ACIP Recommended Immunization Schedule**

Provide the recommended childhood immunization schedule for the United States for January-December of the current year. These recommendations are approved by:

- The Advisory Committee on Immunization Practices (ACIP).
- The American Academy of Pediatrics.
- The American Academy of Family Physicians.

The recommended childhood and adolescent immunization schedule can be accessed on the following web sites: **www.cdc.gov/nip**, **www.aap.org**, or **www.aafp.org**.

**c. Contraindications and Precaution for Immunization**

These conditions apply to DTaP, HBV, Hib, IPV, MMR, pneumococcal conjugate, and varicella as indicated. For more details, see ACIP recommendations (http:www.cdc.gov/nip/publications/ACIP-list.htm).

**DtaP:**

Contraindications:

- Anaphylactic reaction to a prior dose of the vaccine or any of its components
- Encephalopathy within 7 days of a previous dose of DTP or DtaP

Precautions:

- Moderate or severe acute illness
- Underlying unstable, evolving neurologic disorder
- Any of these conditions within the specified time after a previous dose of DTP or DtaP
  - Fever of $\geq$ 40.5ºC (105ºF) unexplained by another cause (within 48 hours)
  - Collapse or shock-like state (within 48 hours)
  - Persistent, inconsolable crying lasting $\geq$ 3 hours (within 48 hours)
  - Seizure or convulsion (within 72 hours)
  - Guillian-Barré syndrome (within 6 weeks)

**Hepatitis A:**

Contraindications:

- Anaphylactic reaction to a prior dose of the vaccine or any of its components (e.g., 2 phenoxyethanol, Alum)

Precautions:

- Moderate or severe acute illness

**Hepatitis B**

Contraindications:

- Anaphylactic reaction to a prior dose of the vaccine or any of its components (e.g., baker's yeast)

Precautions:

- Moderate or severe acute illness

**HIB:**

Contraindications:

- Anaphylactic reaction to a prior dose of the vaccine or any of its components

Precautions:

- Moderate or severe acute illness

**IPV:**

Contraindications:

- Anaphylactic reaction to a prior dose of the vaccine or any of its components (e.g., neomycin, streptomycin, polymyxin B)

Precautions:

- Moderate or severe acute illness
- Pregnancy (If a pregnant woman is at increased risk for infection and requires immediate protection against polio, IPV can be administered in accordance with the recommended schedule for adults.)

**Pneumococcal Conjugate:**

Contraindications:

- Anaphylactic reaction to a prior dose of the vaccine or any of its components

Precautions:

- Moderate or severe acute illness

**MMR:**

Contraindications:

- Anaphylactic reaction to a prior dose of the vaccine or any of its components (e.g., gelatin, neomycin)
- Immunodeficiency (MMR vaccination is recommended for all asymptomatic HIV-infected persons who do not have evidence of severe immunosuppression for whom measles vaccination would otherwise be indicated. It should be considered for all symptomatic HIV-infected persons who do not have evidence of severe immunosuppression or measles immunity.)
- Pregnancy
- TB-untreated, active

Precautions:

- Moderate or severe acute illness
- Recent administration of antibody-containing blood products. (See ACIP General Recommendations for correct spacing.)
- Thrombocytopenia or thrombocytopenic purpura (now or by history)

**Varicella:**

Contraindications:

- Anaphylactic reaction to a prior dose of the vaccine or any of its components (e.g., gelatin, neomycin)
- Immunodeficiency (Varicella vaccination should be considered for asymptomatic or mildly symptomatic HIV infected children. Pure humoral immune deficiencies are not a contraindication to varicella.)
- Pregnancy
- TB – untreated, active

Precautions:

- Moderate or severe acute illness
- Recent administration of antibody-containing blood products (See ACIP General Recommendations for correct spacing.)

**2. Nutritional Status**

To assess nutritional status, include:

- Accurate measurements of height and weight.
- A laboratory test to screen for iron deficiency anemia (see Hgb/Hct procedures on **IX. C.1.** for suggested screening ages).
- Questions about dietary practices to identify:
  - Diets that are deficient or excessive in one or more nutrients.
  - Food allergy, intolerance, or aversion.
  - Inappropriate dietary alterations.
  - Unusual eating habits (such as extended use of bottle feedings, pica, or abnormal behaviors intended to change body weight).

- Complete physical examination, including dental, with special attention to such general features as pallor, apathy, and irritability.
- If feasible, cholesterol measurement for children over two years of age who have increased risk for cardiovascular disease according to these criteria:
  - Parents or grandparent, at 55 years of age or less, underwent diagnostic coronary arteriography and was found to have coronary atherosclerosis or suffered a documented myocardial infarction, peripheral vascular disease, cerebrovascular disease, or sudden cardiac death.
  - A parent who has been found to have high blood cholesterol (240 mg/dL or higher).

**a. Medical Evaluation Indicated (0-12 months)**

Use the following criteria for referring an infant for further medical evaluation due to nutrition status:

- Measurements
  - Weight/Height < 5th percentile or > 95 percentile (NCHS charts).
  - Weight/Age < 5th percentile.
  - Major change in weight/height percentile rank. (A 25 percentile or greater shift in ranking.)
  - Flat growth curve. (Two months without an increase in weight/age of an infant below the 90th percentile weight/age.)
- Laboratory tests
  - < Hct 33%
  - < Hgb 11 gm/dL (6-12 months)
  - ≥ 15 µg/dL blood lead level
- Health problems
  - Metabolic disorder.
  - Chronic disease requiring a special diet.
  - Physical handicap or developmental delay which may alter nutritional status.

- Physical examination: Abnormality of any of the following which indicates poor nutrition: hair, skin or nails, eyes, teeth or gums, disorders of the thyroid or parotid glands, gastrointestinal disorders, neurological disorders, or skeletal disorders.

**b. Medical Evaluation Indicated (1-10 years)**

Use these criteria for referring a child for further medical evaluation of nutrition status:

- Measurements
  - Weight/length < 5th percentile or > 95th percentile for ages 12-23 months.
  - BMI for age < 5th percentile or > 95th percentile for ages 24 months and older.
  - Weight/age < 5th percentile.
  - Major change in weight/height percentile rank. (A 25 percentile or greater shift in ranking.)
  - Flat growth curve:

| Age | Indicator |
|---|---|
| 12 to 36 months | Two months without an increase in weight per age of a child below the 90th percentile weight per age. |
| 3 to 10 years | Six months without an increase in weight per age of a child below the 90th percentile weight per age. |

- Laboratory tests

| Age | HCT % | HGB gm/dL |
|---|---|---|
| 1 up to 2 years | 32.9 | 11.0 |
| 2 up to 5 years | 33.0 | 11.1 |
| 5 up to 8 years | 34.5 | 11.5 |
| 8 up to 10 years | 35.4 | 11.9 |

- Health problems
  - Chronic disease requiring a special diet.
  - Metabolic disorder.
  - Family history of hyperlipidemias.
  - Physical handicap or developmental delay that may alter nutritional status.
- Physical examination: Abnormality of any of the following which indicates poor nutrition: hair, skin or nails, eyes, teeth or gums, disorders of the thyroid or parotid glands, gastrointestinal disorders, neurological disorders, or skeletal disorders.

**c. Medical Evaluation Indicated (11-21 years)**

Use these criteria for referring adolescents for further medical evaluation of nutritional status:

- Laboratory tests

| | FEMALE | | MALE | |
|---|---|---|---|---|
| Age | HCT % | HGB gm/dL | HCT % | HGB gm/dL |
| 11 up to 12* | 35.4 | 11.9 | 35.4 | 11.9 |
| 12 up to 15 | 35.7 | 11.8 | 37.3 | 12.5 |
| 15 up to 18 | 35.9 | 12.0 | 39.7 | 13.3 |
| 18 up to 21 | 35.7 | 12.0 | 39.9 | 13.6 |

Source: Report of the Expert Panel on Blood Cholesterol Levels in Children and Adolescents. U.S. Department of Health and Human Services, September 1991.

- Health problems
  - Chronic disease requiring a special diet.
  - Physical handicap or developmental delay that may alter nutritional status.
  - Metabolic disorder.

- Family history of hyperlipidemias.
- Any behaviors intended to change body weight such as self-induced vomiting, bingeing and purging, use of laxatives or diet pills, skipping meals on a regular basis, excessive exercise.
- Substance use or abuse.

♦ Physical examination. Abnormality of any of the following which indicates poor nutrition: hair, skin or nails, eyes, teeth or gums, disorders of the thyroid or parotid glands, gastrointestinal disorders, neurological disorders, or skeletal disorders.

**3. Vision**

Examination of the eyes should begin in the newborn period and should be done at all well infant and well child visits. Comprehensive examinations of children is recommended to be carried out as a part of the regular plan for continuing care beginning at three years of age.

At each visit, obtain a history to elicit from parents evidence of any visual difficulties. During the newborn period, infants who may be at risk for eye problems include those who are premature (e.g., retinopathy of prematurity) and those with family history of congenital cataracts, retinoblastoma, and metabolic and genetic diseases.

**a. Birth Through Two Years of Age**

Eye evaluations of infants and children birth through two years of age should include:

♦ Eyelids and orbits.
♦ External examinations.
♦ Eye muscle balance.
♦ Pupils.
♦ Red reflex.
♦ Motility.
♦ Monocular fixational ability/assessment

**b. Two to Four Years of Age**

In addition to all the eye evaluations listed for infants and young children, two additional measures should be included. Beginning as early as age 2½ years, children should receive objective vision testing using picture cards. (See the following chart for suggested tests.)

Three-year-old-children who are uncooperative when tested should be retested four to six months later. Make a referral for an eye examination if the child is untestable on the second attempt.

In addition to visual acuity testing, children four years old may cooperate by fixating on a toy while the opthalmoscope is used to evaluate the optic nerve and posterior eye structures.

**c. At Five Years and Older**

Children five years and older should receive all the previously described eye examinations and screening described for younger children.

During the preschool years, muscle imbalance testing is very important. The guidelines above suggest assessing muscle imbalance by use of the corneal light reflex test, unilateral cover test at near and far distance, and random-dot-E test for depth perception.

As the child reaches school age, refractive errors that may require eye glasses for correction become important. The most common refractive error is hyperopia or far-sightedness. Hyperopia can cause problems in performing close work. Therefore, referral to an eye care specialist is recommended. Uncorrected hyperopia is very common in learning-related vision problems.

**VISION SCREENING GUIDELINES**

| Function: Recommended Tests | Referral Criteria | Comments |
|---|---|---|
| **Distance visual acuity:**<br>♦ Snellen letters<br>♦ Snellen numbers<br>♦ Tumbling E<br>♦ HOTV<br>♦ Picture tests<br>• Allen figures<br>• LH test | **Ages 3-5 years:**<br>1. <4 of 6 correct on 20 ft line with either eye tested at 10 ft monocularly (i.e., <10/20 or 20/40)<br>or<br>2. Two-line difference between eyes, even within the passing range (i.e., 10/12.5 and 10/20 or 20/25 and 20/40)<br><br>**Ages 6 years and older:**<br>1. <4 of 6 correct on 15 ft line with either eye tested at 10 ft monocularly (i.e., <10/15 or 20/30)<br>2. Two-line difference between eyes, even within the passing range (i.e., 10/10 and 10/15 or 20/20 and 20/30) | 1. Tests are listed in decreasing order of cognitive difficulty. Use the highest test that the child is capable of performing. In general, the tumbling E or the HOTV test should be used for ages 3-5 years and Snellen letters or numbers for ages 6 years and older.<br>2. Testing distance of 10 ft is recommended for all visual acuity tests.<br>3. A line of figures is preferred over single figures.<br>4. The nontested eye should be covered by an occluder held by the examiner or by an adhesive occluder patch applied to eye. The examiner must ensure that it is not possible to peek with the nontested eye. |
| **Ocular alignment:**<br>♦ Unilateral cover test at 10 ft or 3 m<br>or<br>♦ Random-dot-E stereo test at 40 cm (630 s of arc) | Any eye movement<br><br><4 of 6 correct | |

Source: Vision screening guidelines developed by the AAP Section on Ophthalmology Executive Committee, 1991-1992. ***Pediatrics***, Vol. 98 No. 1, July 1996.

### 4. Hearing

Objective screening of hearing for all neonates is now recommended by multiple professional medical, audiology, and early childhood education groups. Objective hearing screening performed on newborns and infants will detect congenital hearing loss, but will not identify those children with progressive hearing loss.

Thus, objective hearing screening for all children should be a regular procedure conducted during well-child health screening appointments according to the periodicity schedule. Using high risk factor subjective screening methods is no longer an acceptable alternative to objective hearing screening during early childhood.

Objective hearing screening should be performed on all infants by age three months. Newborn infants who have **not** had an objective hearing test should be referred to an audiologist who specializes in infant screening using one of the latest audiology screening technologies. There are multiple public and private audiologists serving infants and toddlers.

Other types of objective hearing screening, such as "play audiometry" may begin as soon as a child is developmentally able to understand the procedure and cooperate. Audiometry is typically performed at frequencies of 500, 1000, 2000, 4000, and 6000 Hz at 20 decibels for both ears.

#### a. Subjective Hearing Screening

Subjective screening of hearing may be performed by history and observation during health visits occurring between the appointed times for objective hearing screening according to the periodicity schedule.

#### b. Referral Criteria

A child of any age who has not had objective hearing screening should be referred for audiology evaluation to rule out congenital hearing loss.

The following children should be referred for objective audiology evaluation:

- A child with congenital anomaly of the ear, nose, throat, or kidney
- A child with behavior problems
- A child with developmental delay of onset of speech
- A child with recurrent upper respiratory infections
- A child with a family history of hearing loss
- A child who does not respond to pure tone testing at any of the levels screened

If the parent has any concern about the child's hearing, refer the child for objective audiology evaluation.

Unless a medical problem is apparent, an audiological examination is usually needed before referral or in conjunction with the referral to medical specialist.

# I. REQUEST FOR PRIOR AUTHORIZATION FORM AND INSTRUCTIONS

## A. How to Use

Since there are different requirements for requesting prior authorization for services than for drugs, sections A, B, and C relate to requests for services; sections D, E, and F deal with requests for drugs.

For those services requiring prior approval (see Chapter E), form 470-0829, *Request for Prior Authorization*, must be completed and submitted to the fiscal agent. The request will be reviewed by the Medical Unit and a determination of coverage will be made. When a determination has been made, the form will be returned to you. Do not use this form unless prior approval is required by Medicaid for the service being provided.

If the service is approved for coverage, you may then submit your claim for reimbursement. **Important:** Do not return the prior authorization form. You need to place the prior authorization number in the appropriate location on your claim form. (Consult the claim form instructions.) Using this number, the computer will then verify that the service has been approved for payment.

## B. Facsimile of Request for Prior Authorization

(See page F - 3.)

## C. Instructions for Completing Request for Prior Authorization

1. PATIENT NAME
   Complete the last name, first name and middle initial of the patient. Use the *Medical Assistance Eligibility Card* for verification.

2. PATIENT IDENTIFICATION NUMBER
   Copy this number directly from the *Medical Assistance Eligibility Card*. This number must be eight positions in length (seven numeric digits and one alphabetical character).

3. COUNTY NO.
   This is the number of the county where the recipient resides. It may be copied from the *Medical Assistance Eligibility Card*. This is a two-digit code. This area is optional.

4. DATE OF BIRTH
   Copy the patient's date of birth directly from the *Medical Assistance Eligibility Card*. Use two digits for each: month, day, year (MM, DD, YY).

5. PROVIDER PHONE NO.
   Completing this area may expedite the processing of your *Request for Prior Authorization*. This area is optional.

6. PROVIDER NO.
   Enter the seven-digit Medicaid provider number of the treating physician.

7. PAY TO PROVIDER NO.
   Enter the seven-digit provider number assigned to you by the Iowa Medicaid Program. If you have a clinical agreement with Iowa Medicaid, enter your seven-digit group provider number.

8. DATES COVERED BY THIS REQUEST
   Enter the appropriate date span. Be sure to include the date of service. Complete this item using two digits for each: month, day, year (MM, DD, YY). If this request is approved, it will be valid only for this period of time.

9. PROVIDER NAME
   Enter the name of the provider requesting prior authorization.

10. STREET ADDRESS
    Enter the street address of the provider requesting prior authorization.

11. CITY, STATE, ZIP
    Enter the city, state and zip of the provider requesting prior authorization.

Iowa Department of Human Services

# REQUEST FOR PRIOR AUTHORIZATION

(PLEASE TYPE - ACCURACY IS IMPORTANT)

| 1. Patient Name (Last) (First) (Initial) | | | 2. Patient Identification No. | 3. Co. No. | 4. Date of Birth Mo. Day Year |
|---|---|---|---|---|---|
| 5. Provider Phone No. | 6. Provider No. | 7. Pay to Provider No. | 8. Dates Covered by Request | | |
| 9. Provider Name | | | From: Mo. / Day / Year | To: Mo. / Day / Year | |
| 10. Street Address | | | 12. PRIOR AUTHORIZATION NO. (To be assigned by fiscal agent) Enter this number in the appropriate box when submitting the claim form for the services authorized. | | |
| 11. City, State, Zip | | | | | |

13. Reasons For Request (use additional sheet if necessary)

**SERVICES TO BE AUTHORIZED**

| 14. Line No. | 15. Describe Procedure, Supply, Drug To Be Provided or Diagnosis Description | 16. Procedure, Supply, Drug or Diagnosis Code* | 17. Units of Service | 18. Leave Blank Authorized Units | 19. Amount | 20. Leave Blank Authorized Amount | 21. Leave Blank Status |
|---|---|---|---|---|---|---|---|
| 01 | | | | | | | |
| 02 | | | | | | | |
| 03 | | | | | | | |
| 04 | | | | | | | |
| 05 | | | | | | | |

IF THE PROVIDER OF THESE SERVICES WILL BE OTHER THAN THE PROVIDER NAMED IN BOX 9, PLEASE COMPLETE THIS PORTION.

| 22. Provider Name | 23. Telephone No. | 24. Provider No. | 25. Pay to Provider No. |
|---|---|---|---|
| 26. Street Address | | City / State / Zip | |

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the recipient continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the recipient's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the recipient continues to be eligible for Medicaid.

27. Requesting provider

_____ _____

Signature of Authorized Representative — Date

**FISCAL AGENT USE ONLY**

28. MEDICAID BENEFITS ARE HEREBY ❑ APPROVED ❑ DENIED FOR THE RECIPIENT UNDER TITLE XIX, THIS AUTHORIZATION APPLIED ONLY TO THE ELIGIBLE PERSON ABOVE FOR THE SERVICE(S) SPECIFICALLY APPROVED ABOVE.

29. Comments or Reasons for Denial of Benefits

*PROCEDURE, SUPPLY, DRUG OR DIAGNOSIS CODES AUTHORIZED ON THIS REQUEST MUST BE THE SAME CODES ENTERED ON THE CLAIM FORM

30. Signature

_____ _____

Fiscal Agent's Authorized Representative — Date

Page 4 was intentionally left blank.

12. PRIOR AUTHORIZATION NO.
Leave blank.
The fiscal agent will assign a number if the service is approved. You will then place this number in the appropriate area on the claim form.

13. REASON FOR REQUEST
Provide the required information in this area for the type of approval being requested. Refer to the Coverage and Limitations section of this manual.

SERVICES TO BE AUTHORIZED

14. LINE NO.
No entry is required.

15. DESCRIBE PROCEDURE, SUPPLY, DRUG TO BE PROVIDED OR DIAGNOSIS DESCRIPTION
Enter the description of the service or services to be authorized.

16. PROCEDURE, SUPPLY, DRUG OR DIAGNOSIS CODE
Enter the appropriate code. For prescription drugs, enter the appropriate NDC. For other services or supplies, enter the proper HCPCS code.

17. UNITS OF SERVICE
Complete with the amount or number of times the service is to be performed.

18. AUTHORIZED UNITS
Leave blank. The fiscal agent will indicate the number of authorized units.

19. AMOUNT
Enter the amount that will be charged for this line item.

20. AUTHORIZED AMOUNT
Leave blank. The fiscal agent will indicate the authorized amount or indicate that payment will be based on the fee schedule or maximum fee depending on the service provided.

21. STATUS
Leave blank. The fiscal agent will indicate “A” for approved or “D” for denied.

22. PROVIDER NAME
Complete the name of the provider who will provide services, if other than requestor of prior authorization.

23. TELEPHONE NO.
Enter the telephone number of the provider who will provide services, if other than requestor of prior authorization. This area is optional.

24. PROVIDER NO.
Enter the seven-digit Medicaid provider number of the treating physician, if other than requestor of prior authorization.

25. PAY TO PROVIDER NO.
Enter the seven-digit group provider number for the treating physician, if other than requestor of prior authorization.

26. STREET ADDRESS, CITY, STATE, ZIP
Complete the street address, city, state and zip of the provider who will provide services, if other than requestor of prior authorization.

27. REQUESTING PROVIDER
Enter the signature of the provider or authorized representative requesting prior authorization. Also, indicate the date the request was signed.

FISCAL AGENT USE ONLY

28. MEDICAID BENEFITS REQUESTED ARE HEREBY
Do not complete. The fiscal agent will complete this item after evaluating the request.

29. COMMENTS OR REASON FOR DENIAL OF BENEFITS
Do not complete. The fiscal agent will complete this section should this request be denied.

30. SIGNATURE
Do not complete. The person making the final decision on this request will sign and date.

Iowa Medicaid Program

# Prior Authorization Attachment Control

**Please use this form when submitting a prior authorization electronically which requires an attachment. The attachment can be submitted on paper along with this form. The "Attachment Control Number" submitted on this form must be the same "attachment control number" submitted on the electronic prior authorization. Otherwise the electronic prior authorization and paper attachment cannot be matched up.**

**Attachment Control Number**

| | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | | | |

**Provider Name** _____

**Pay-to-Provider Number**

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | |

**Recipient Name** _____

**Recipient State ID Number**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

**Date of Service** ____/____/_____

**Type of Document**

_____

_____

_____

**RETURN THIS DOCUMENT WITH ATTACHMENTS TO:**
**ACS State Healthcare**
**P.O. Box 9157**
**Des Moines, IA 50306-3422**
**PA FAX: 515-327-5127**

## D. Electronic Prior Authorization Requests

Under the Health Insurance Portability and Accountability Act, there is an electronic transaction for Prior Authorization requests (278 transaction). However, there is no standard to use in submitting additional documentation electronically. Therefore, if you want to submit a prior authorization request electronically, the additional documentation must be submitted on paper using the following procedure:

- Staple the additional information to form 470-3970, *Prior Authorization Attachment Control*. (See the previous page for an example of this form.)
- Complete the "attachment control number" with the same number submitted on the electronic prior authorization request. ACS will accept up to 20 characters (letters or digits) in this number. If you do not know the attachment control number for the request, please contact the person in your facility responsible for electronic claims billing.
- Mail the *Prior Authorization Attachment Control* with attachments to:

  ACS State Healthcare
  P.O. Box 9157
  Des Moines, IA 50306-3422

  Or FAX the information to the Prior Authorization Unit at: 515-327-5127

Once ACS receives the paper attachment, it will manually be matched up to the electronic prior authorization using the attachment control number and then processed.

**Note:** This procedure does not apply to drug prior authorizations. Please continue to follow current procedures. (See Item E, below.)

## E. How to Request Authorization for Drugs

Prior authorization for drug requests may be made via telephone, FAX, or mail, to the ACS Drug Prior Authorization Unit. If the pharmacy provider information is not available, the request may be processed without it. When you require the pharmacy to request prior authorization, including the diagnosis on the prescription is helpful.

Requests from the physician or pharmacy require the information designated on form 470-0829, *Request for Prior Authorization*. Use form 470-0829 to request a drug prior authorization by FAX or mail. (Have the information requested on the form available when making the request by phone.)

The instructions for completing form 470-0829 are in the previous section. You may copy these forms or order additional forms from the ACS Provider Relations Unit.

The pharmacist reviewer will make a decision and respond within 24 hours of the request. Requests received after regular working hours (8:30 AM to 5:30 PM, M-F and 9:00 AM to 3:00 PM, Sat/Sun) will be considered to be received at the start of the next working day. If the after hours or weekend request is for an emergency need, a 72-hour supply may be dispensed and reimbursement will be made.

### 1. Telephone Requests

Telephone requests provide the quickest response to a prior authorization request. The local and toll-free telephone lines are answered from 8:30 AM to 5:30 PM, Monday through Friday and from 9:00 AM to 3:00 PM, Sat/Sun.

When making the request by phone, have the solicited information from the Medicaid *Request for Prior Authorization* available. State the diagnosis, total medical condition of the patient, and previous therapeutic trials when required. When you require the pharmacy to request a prior authorization, including the diagnosis on the prescription is helpful.

**2. FAX/Mail Requests**

Transmission of the prior authorization request by FAX will generate a faster response than transmission through the mail, but telephone transmission provides for the quickest response. The ACS Drug Prior Authorization Unit fax number is 1-515-327-0945.

FAX and mail transmissions must state the complete information designated on form 470-0829, *Request for Prior Authorization.* Providers may copy the request form or order additional forms from the ACS Provider Relations Unit.

**3. Prior Authorization Response**

If a request is denied, the reviewer will make a telephone response and a letter of denial will be sent to the requestor and the recipient.

In evaluating requests for prior authorization, the pharmacist reviewer will consider the drug from the standpoint of published criteria only. If the approval is granted, this does not indicate that the patient continues to be eligible for Medicaid, nor does it indicate validity of the prescription.

It is your responsibility to establish eligibility by inspection of the recipient's Medicaid eligibility card, or by calling the voice response system at 800-338-7752 or 515-327-2181.

Upon approval of a prior authorization request, the reviewer will notify the submitting provider of the decision and issue the prior authorization number and dates of authorization.

Physicians requesting the prior authorization are responsible for notifying the pharmacy of the prior approval number, since approval is required for claims processing and reimbursement. Prior authorization requests may be submitted by either the physician or the pharmacy provider.

# II. INSTRUCTIONS AND CLAIM FORM

## A. Instructions for Completing the Claim Form

The table below contains information that will aid in the completion of the HCFA-1500 claim form. The table follows the form by field number and name, giving a brief description of the information to be entered, and whether providing information in that field is required, optional or conditional of the individual recipient's situation.

A star (*) in the instructions area of the table indicates a new item or change in policy for Iowa Medicaid providers.

*For electronic media claim (EMC) submitters, refer also to your EMC specifications for claim completion instructions.*

| FIELD NUMBER | FIELD NAME/ DESCRIPTION | INSTRUCTIONS |
|---|---|---|
| 1. | CHECK ONE | **OPTIONAL** – Check the applicable program block. |
| 1a. | INSURED'S ID NUMBER | **REQUIRED** – Enter the recipient's Medicaid ID number found on the *Medical Assistance Eligibility Card*. It should consist of seven digits followed by a letter, i.e., 1234567A. |
| 2. | PATIENT'S NAME | **REQUIRED** – Enter the last name, first name and middle initial of the recipient. Use the *Medical Assistance Eligibility Card* for verification. |
| 3. | PATIENT'S BIRTHDATE | **OPTIONAL** – Enter the patient's birth month, day, year and sex. Completing this field may expedite processing of your claim. |

| | | |
|---|---|---|
| 4. | INSURED'S NAME | **CONDITIONAL*** – If the recipient is covered under someone else's insurance, enter the name of the person under which the insurance exists. This could be insurance covering the recipient as a result of a work or auto related accident.<br><br>**Note:** This section of the form is separated by a border, so that information on this other insurance follows directly below, even though the numbering does not. |
| 5. | PATIENT'S ADDRESS | **OPTIONAL** – Enter the address and phone number of the patient, if available. |
| 6. | PATIENT RELATIONSHIP TO INSURED | **CONDITIONAL*** – If the recipient is covered under another person's insurance, mark the appropriate box to indicate relation. |
| 7. | INSURED'S ADDRESS | **CONDITIONAL*** – Enter the address and phone number of the insured person indicated in field number 4. |
| 8. | PATIENT STATUS | **OPTIONAL** – Check boxes corresponding to the patient's current marital and occupational status. |
| 9a-d. | OTHER INSURED'S NAME | **CONDITIONAL*** – If the recipient carries other insurance, enter the name under which that insurance exists, as well as the policy or group number, the employer or school name under which coverage is offered and the name of the plan or program. |
| 10. | IS PATIENT'S CONDITION RELATED TO | **CONDITIONAL*** – Check the appropriate box to indicate whether or not treatment billed on this claim is for a condition that is somehow work or accident related. If the patient's condition is related to employment or an accident, and other insurance has denied payment, complete 11d, marking the "YES" and "NO" boxes. |
| 10d. | RESERVED FOR LOCAL USE | **OPTIONAL** – No entry required. |

| | | |
|---|---|---|
| 11a-c. | INSURED'S POLICY GROUP OR FECA NUMBER AND OTHER INFORMATION | **CONDITIONAL*** – This field continues with information related to field 4. If the recipient is covered under someone else's insurance, enter the policy number and other requested information as known. |
| 11d. | IS THERE ANOTHER HEALTH BENEFIT PLAN? | **CONDITIONAL** – If payment has been received from another insurance, or the medical resource codes on the eligibility card indicate other insurance exists, check "YES" and enter payment amount in field 29.<br><br>If you have received a denial of payment from another insurance, check both "YES" and "NO" to indicate that there is other insurance, but that the benefits were denied.<br><br>**Note:** Auditing will be performed on a random basis to ensure correct billing. |
| 12. | PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE | **OPTIONAL** – No entry required. |
| 13. | INSURED OR AUTHORIZED PERSON'S SIGNATURE | **OPTIONAL** – No entry required. |
| 14. | DATE OF CURRENT ILL-NESS, INJURY, PREGNANCY | **CONDITIONAL*** – Chiropractors must enter the date of the onset of treatment as month, day and year. All others – no entry required. |
| 15. | IF THE PATIENT HAS HAD SAME OR SIMILAR ILLNESS… | **CONDITIONAL** – Chiropractors must enter the current x-ray date as month, day and year. All others – no entry required. |
| 16. | DATES PATIENT UNABLE TO WORK… | **OPTIONAL** – No entry required. |

| | | |
|---|---|---|
| 17. | NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | **CONDITIONAL** – Required if the referring physician does not have a Medicaid number. |
| 17a. | ID NUMBER OF REFERRING PHYSICIAN | **CONDITIONAL*** –<br><br>If the patient is a MediPASS recipient and the MediPASS physician authorized service, enter the seven-digit MediPASS authorization number.<br><br>If this claim is for consultation, independent lab or DME, enter the Iowa Medicaid number of the referring or prescribing physician.<br><br>If the patient is on lock-in and the lock-in physician authorized service, enter the seven-digit authorization number. |
| 18. | HOSPITALI-ZATION DATES RELATED TO… | **OPTIONAL** – No entry required. |
| 19. | RESERVED FOR LOCAL USE | **REQUIRED** – If the patient is pregnant, write "Y – Pregnant." |
| 20. | OUTSIDE LAB | **OPTIONAL** – No entry required. |
| 21. | DIAGNOSIS OR NATURE OF ILLNESS | **REQUIRED** – Indicate the applicable ICD-9-CM diagnosis codes in order of importance (1-primary; 2-secondary; 3-tertiary; and 4-quaternary) to a maximum of four diagnoses. |
| 22. | MEDICAID RESUBMISSION CODE… | **OPTIONAL** – No entry required. |
| 23. | PRIOR AUTHORIZATION NUMBER | **CONDITIONAL*** – Enter the prior authorization number issued by ACS. |

| | | |
|---|---|---|
| 24. A | DATE(S) OF SERVICE | **REQUIRED** – Enter month, day and year under both the From and To categories for each procedure, service or supply. If the From-To dates span more than one calendar month, represent each month on a separate line. Because eligibility is approved on a month-by-month basis, spanning or overlapping billing months could cause the entire claim to be denied. |
| 24. B | PLACE OF SERVICE | **REQUIRED** – Using the chart below, enter the number corresponding to the place service was provided. Do not use alphabetic characters.<br>11 Office<br>12 Home<br>21 Inpatient hospital<br>22 Outpatient hospital<br>23 Emergency room – hospital<br>24 Ambulatory surgical center<br>25 Birthing center<br>26 Military treatment facility<br>31 Skilled nursing<br>32 Nursing facility<br>33 Custodial care facility<br>34 Hospice<br>41 Ambulance – land<br>42 Ambulance – air or water<br>51 Inpatient psychiatric facility<br>52 Psychiatric facility – partial hospitalization<br>53 Community mental health center<br>54 Intermediate care facility/mentally retarded<br>55 Residential substance abuse treatment facility<br>56 Psychiatric residential treatment center<br>61 Comprehensive inpatient rehabilitation facility<br>62 Comprehensive outpatient rehabilitation facility<br>65 End-stage renal disease treatment<br>71 State or local public health clinic<br>72 Rural health clinic<br>81 Independent laboratory<br>99 Other unlisted facility |

| | | |
|---|---|---|
| 24. C | TYPE OF SERVICE | **OPTIONAL** – No entry required. |
| 24. D | PROCEDURES, SERVICES OR SUPPLIES | **REQUIRED** – Enter the appropriate five-digit procedure code and any necessary modifier for each of the dates of service. DO NOT list services for which no fees were charged. |
| 24. E | DIAGNOSIS CODE | **REQUIRED** – Indicate the corresponding diagnosis code from field 21 by entering the number of its position, i.e., 3. DO NOT write the actual diagnosis code in this field. Doing so will cause the claim to deny. There is a maximum of four diagnosis codes per claim. |
| 24. F | $ CHARGES | **REQUIRED** – Enter the usual and customary charge for each line item. |
| 24. G | DAYS OR UNITS | **REQUIRED** – Enter the number of times this procedure was performed or number of supply items dispensed. If the procedure code specifies the number of units, then enter "1." When billing general anesthesia, the units of service must reflect the total minutes of general anesthesia. |
| 24. H | EPSDT/FAMILY PLANNING | **OPTIONAL*** – Enter an "F" if the services on this claim line are for family planning. Enter an "E" if the services on this claim line are the result of an EPSDT Care for Kids screening. |
| 24. I | EMG | **OPTIONAL** – No entry required. |
| 24. J | COB | **OPTIONAL** – No entry required. |
| 24. K | RESERVED FOR LOCAL USE | **CONDITIONAL*** – Enter the treating provider's individual seven-digit Iowa Medicaid provider number when the provider number given in field 33 is that of a group and/or is not that of the treating provider. |
| 25. | FEDERAL TAX ID NUMBER | **OPTIONAL** – No entry required. |
| 26. | PATIENT'S ACCOUNT NUMBER | **OPTIONAL** – Enter the account number assigned to the patient by the provider of service. This field is limited to 10 alpha/numeric characters. |

| | | |
|---|---|---|
| 27. | ACCEPT ASSIGNMENT? | **OPTIONAL** – No entry required. |
| 28. | TOTAL CLAIM CHARGE | **REQUIRED** – Enter the total of the line item charges. If more than one claim form is used to bill services performed, each claim form must be separately totaled. Do not carry over any charges to another claim form. |
| 29. | AMOUNT PAID | **CONDITIONAL*** – Enter only the amount paid by other insurance. Recipient co-payments, Medicare payments or previous Medicaid payments are not listed on this claim. |
| 30. | BALANCE DUE | **REQUIRED*** – Enter the amount of total charges less the amount entered in field 29. |
| 31. | SIGNATURE OF PHYSICIAN OR SUPPLIER | **REQUIRED** – The signature of either the physician or authorized representative and the original filing date must be entered. If the signature is computer-generated block letters, the signature must be initialed. A signature stamp may be used. |
| 32. | NAME AND ADDRESS OF FACILITY… | **CONDITIONAL** – If other than a home or office, enter the name and address of the facility where the service(s) were rendered. |
| 33. | PHYSICIAN'S, SUPPLIER'S BILLING NAME… | **REQUIRED*** – Enter the complete name and address of the billing physician or service supplier. |
| | GRP # | **REQUIRED** – Enter the seven-digit Iowa Medicaid number of the billing provider.<br><br>If this number identifies a group or an individual provider other than the provider of service, the treating provider's Iowa Medicaid number must be entered in field 24K for each line. |
| **BACK OF FORM** | NOTE | **REQUIRED** – The back of the claim form must be intact on every claim form submitted. |

## B. Facsimile of Claim Form, HCFA-1500 (front and back)

(See the following pages.)

APPROVED OMB-0938-0008

PICA

# HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO *If yes*, return to and complete item 9 a-d.

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. ____ 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| 24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | | | | | | | | | |
| 2 | | | | | | | | | | |
| 3 | | | | | | | | | | |
| 4 | | | | | | | | | | |
| 5 | | | | | | | | | | |
| 6 | | | | | | | | | | |

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

***PLEASE PRINT OR TYPE***

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

**BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.**

**NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.**

**REFERS TO GOVERNMENT PROGRAMS ONLY**

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

**BLACK LUNG AND FECA CLAIMS**

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

**SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)**

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

**NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION**
(PRIVACY ACT STATEMENT)

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101;41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

**FOR MEDICARE CLAIMS:** See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

**FOR OWCP CLAIMS:** Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

**FOR CHAMPUS CLAIMS:** PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

**MEDICAID PAYMENTS (PROVIDER CERTIFICATION)**

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Humans Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

**SIGNATURE OF PHYSICIAN (OR SUPPLIER):** I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing date sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to HCFA, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (OMB-0938-0008), Washington, D.C. 20503.

Iowa Medicaid Program

# Claim Attachment Control

**Please use this form when submitting a claim electronically which requires an attachment. The attachment can be submitted on paper along with this form. The "Attachment Control Number" submitted on this form must be the same "attachment control number" submitted on the electronic claim. Otherwise the electronic claim and paper attachment cannot be matched up.**

**Attachment Control Number**

| | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | | | | | | | | | |

**Provider Name** _____

**Pay-to-Provider Number**

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | | |

**Recipient Name** _____

**Recipient State ID Number**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

**Date of Service** ____/____/_____

**Type of Document**

_____

_____

_____

**RETURN THIS DOCUMENT WITH ATTACHMENTS TO:**
**ACS State Healthcare**
**P.O. Box 14422**
**Des Moines, IA 50306-3422**

### C. Claim Attachment Control, Form 470-3969

If you want to submit electronically a claim that requires an attachment, you must submit the attachment on paper using the following procedure:

- Staple the additional information to form 470-3969, *Claim Attachment Control*. (See the page following the claim form for an example of this form.)
- Complete the "attachment control number" with the same number submitted on the electronic claim. ACS will accept up to 20 characters (letters or digits) in this number. If you do not know the attachment control number for the claim, please contact the person in your facility responsible for electronic claims billing.
- Do not attach a paper claim.
- Mail the *Claim Attachment Control* with attachments to:

  ACS State Healthcare
  P.O. Box 14422
  Des Moines, IA 50306-3422

Once ACS receives the paper attachment, it will manually be matched up to the electronic claim using the attachment control number and then processed.

## III. REMITTANCE ADVICE AND FIELD DESCRIPTIONS

### A. Remittance Advice Explanation

To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting.

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied and suspended claims. PAID indicates all processed claims, credits and adjustments for which there is full or partial reimbursement.

DENIED represents all processed claims for which no reimbursement is made. SUSPENDED reflects claims which are currently in process pending resolution of one or more issues (recipient eligibility determination, reduction of charges, third party benefit determination, etc.).

Suspended claims may or may not print depending on which option was specified on the Medicaid Provider Application at the time of enrollment. You chose one of the following:

- Print suspended claims only once.
- Print all suspended claims until paid or denied.
- Do not print suspended claims.

Note that claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a "1" in the twelfth position and reimbursement appears as a negative amount. An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a "2" in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit – the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

An example of the *Remittance Advice* and a detailed field-by-field description of each informational line follows. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

Regardless of one's understanding of the *Remittance Advice*, it is sometimes necessary to contact the fiscal agent with questions. When doing so, keep the *Remittance Advice* handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

## B. Facsimile of Remittance Advice and Detailed Field Descriptions

(See the following page.)

MEDICAID MANAGEMENT INFORMATION SYSTEM RUN DATE 06/12/97

# REMITTANCE ADVICE

(1.) TO: [redacted] (2.) R.A. NO.: 0000006 (3.) DATE PAID: 05/19/97 (4.) PROVIDER NUMBER: [redacted] (5.) PAGE: 1

| **** PATIENT NAME **** LAST | FIRST MI | RECIP ID / LINE | TRANS-CONTROL-NUMBER / SVC-DATE | PROC/MODS | UNITS | BILLED AMT. | OTHER SOURCES | PAID BY MCAID | COPAY AMT. | MED RCD NUM / PERF. PROV. | S | EOB | EOB |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| * (6.) CLAIM TYPE: HCFA 1500 | | | | | | * (7.) CLAIM STATUS: PAID | | | | | | | |
| ORIGINAL CLAIMS: | | | (10.) | | | (11.) | (12.) | (13.) | (14.) | (15.) | | (16.) | |
| [redacted] (8.) | [redacted] | (9.) [redacted] | 4-96331-00-053-0038-00 | | | 38.00 | 0.00 | 16.06 | 0.00 | 860600608B | | 900 | 000 |
| | | (17.) 01 | (18.) 10/3 (19.) | 99212 | (20.) 1 | (21.) 38.00 | (22.) 0.00 | (23.) 16.06 | (24.) 0.00 | (25.) [redacted] | | | 000 000 |
| [redacted] | [redacted] | [redacted] | 4-96348-00-018-0060-00 | | | 50.00 | 0.00 | 35.26 | 0.00 | 860600608B | | | 000 000 |
| | | 01 | 11/15/96 | J1055 | 1 | 41.00 | 0.00 | 33.18 | 0.00 | [redacted] | (26.) | F | 000 000 |
| | | 02 | 11/15/96 | 90782 | 1 | 9.00 | 0.00 | 2.08 | 0.00 | [redacted] | | F | 000 000 |

(27.)

| REMITTANCE TOTALS | | | | | |
|---|---|---|---|---|---|
| PAID ORIGINAL CLAIMS: | NUMBER OF CLAIMS | 2 | --------- | 88.00 | 51.32 |
| PAID ADJUSTMENT CLAIMS: | NUMBER OF CLAIMS | 0 | --------- | 0.00 | 0.00 |
| DENIED ORIGINAL CLAIMS: | NUMBER OF CLAIMS | 0 | --------- | 0.00 | 0.00 |
| DENIED ADJUSTMENT CLAIMS: | NUMBER OF CLAIMS | 0 | --------- | 0.00 | 0.00 |
| PENDED CLAIMS (IN PROCESS): | NUMBER OF CLAIMS | 0 | --------- | 0.00 | 0.00 |
| AMOUNT OF CHECK: | | | | | 51.32 |

---- THE FOLLOWING IS A DESCRIPTION OF THE EXPLANATION OF BENEFIT (EOB) CODES THAT APPEAR ABOVE:

(28.) 900 THE CLAIM IS IN SUSPENSE. DO NOT RESUBMIT THE CLAIM.

Page 22 was intentionally left blank.

## C. Remittance Advice Field Descriptions

1. Billing provider's name as specified on the Medicaid Provider Enrollment Application.

2. *Remittance Advice* number.

3. Date claim paid.

4. Billing provider's Medicaid (Title XIX) number.

5. *Remittance Advice* page number.

6. Type of claim used to bill Medicaid.

7. Status of following claims:

   - **Paid** – claims for which reimbursement is being made.
   - **Denied** – claims for which no reimbursement is being made.
   - **Suspended** – claims in process. These claims have not yet been paid or denied.

8. Recipient's last and first name.

9. Recipient's Medicaid (Title XIX) number.

10. Transaction control number assigned to each claim by the fiscal agent. Please use this number when making claim inquires.

11. Total charges submitted by provider.

12. Total amount applied to this claim from other resources, i.e., other insurance or spenddown.

13. Total amount of Medicaid reimbursement as allowed for this claim.

14. Total amount of recipient copayment deducted from this claim.

15. Medical record number as assigned by provider; 10 characters are printable.

16. Explanation of benefits code for informational purposes or to explain why a claim denied. Refer to the end of *Remittance Advice* for explanation of the EOB code.

17. Line item number.

18. The first date of service for the billed procedure.

19. The procedure code for the rendered service.

20. The number of units of rendered service.

21. Charge submitted by provider for line item.

22. Amount applied to this line item from other resources, i.e., other insurance, spenddown.

23. Amount of Medicaid reimbursement as allowed for this line item.

24. Amount of recipient copayment deducted for this line item.

25. Treating provider's Medicaid (Title XIX) number.

26. Allowed charge source code:

**B** Billed charge
**F** Fee schedule
**M** Manually priced
**N** Provider charge rate
**P** Group therapy
**Q** EPSDT total screen over 17 years
**R** EPSDT total under 18 years
**S** EPSDT partial over 17 years
**T** EPSDT partial under 18 years
**U** Gynecology fee
**V** Obstetrics fee
**W** Child fee

27. Remittance totals (found at the end of the *Remittance Advice*):

- Number of paid original claims, the amount billed by the provider and the amount allowed and reimbursed by Medicaid.
- Number of paid adjusted claims, amount billed by provider and amount allowed and reimbursed by Medicaid.
- Number of denied original claims and amount billed by provider.
- Number of denied adjusted claims and amount billed by provider.
- Number of pended claims (in process) and amount billed by provider.
- Amount of check.

28. Description of individual explanation of benefits codes. The EOB code leads, followed by important information and advice.

# IV. PROBLEMS WITH SUBMITTED CLAIMS

To inquire as to why a claim was denied or why a claim payment was not what you expected, please complete form 470-3744, *Provider Inquiry*. Attach copies of the claim, the *Remittance Advice,* and any supporting documentation you want to have considered, such as additional medical records. Send these to:

ACS, Attn: Provider Inquiry
PO Box 14422
Des Moines, Iowa 50306-3422

To make an adjustment to a claim following receipt of the *Remittance Advice,* use form 470-0040, *Credit/Adjustment Request*. Use the *Credit/Adjustment Request* to notify the fiscal agent to take an action against a paid claim, such as when:

- A paid claim amount needs to be changed, or
- Money needs to be credited back, or
- An entire *Remittance Advice* should be canceled.

Send this form to:

ACS, Attn: Credits and Adjustments
PO Box 14422
Des Moines, Iowa 50306-3422

Do **not** use this form when a claim has been denied. Denied claims must be resubmitted.

## A. Facsimile of Provider Inquiry, 470-3744

You can obtain this form by printing or copying the sample in the manual or contacting the fiscal agent. A facsimile of the form follows.

## B. Facsimile of Credit/Adjustment Request, 470-0040

You can obtain this form by printing or copying the sample in the manual or contacting the fiscal agent. A facsimile of the form follows.

Iowa Medicaid Program

# PROVIDER INQUIRY

Attach supporting documentation. Check applicable boxes: ❒ Claim copy ❒ Remittance copy
❑ Other pertinent information for possible claim reprocessing.

**INQUIRY A**

**1. 17-DIGIT TCN**

**2. NATURE OF INQUIRY**

(Please do not write below this line)
**FISCAL AGENT RESPONSE**

**INQUIRY B**

**1. 17–DIGIT TCN**

**2. NATURE OF INQUIRY**

(Please do not write below this line)
**FISCAL AGENT RESPONSE**

| **Provider Signature/Date:** | **MAIL TO: ACS<br>P. O. BOX 14422<br>DES MOINES IA 50306-3422** | **ACS Signature/Date:** |
|---|---|---|

**Provider Please Complete:**

7-digit Medicaid Provider ID#_____

Telephone_____

Name
Street
City, St
Zip

(FOR ACS USE ONLY)

PR Inquiry Log #_____

**Received Date Stamp:**

Page 28 was intentionally left blank.

**Iowa Medicaid Program**

# CREDIT/ADJUSTMENT REQUEST

Do **not** use this form if your claim was denied. Resubmit denied claims.

**SECTION A: Check the most appropriate action and complete steps for that request.**

| ❑ CLAIM ADJUSTMENT | ❑ CLAIM CREDIT | ❑ CANCELLATION OF ENTIRE REMITTANCE ADVICE |
|---|---|---|
| ♦ Attach a complete copy of claim. (If electronic, use next step.)<br>♦ Attach a copy of the Remittance Advice with corrections in **red ink**.<br>♦ Complete Sections B and C. | ♦ Attach a copy of the Remittance Advice.<br>♦ Complete Sections B and C. | ♦ Use only if all claims on Remittance Advice are incorrect. This option is rarely used.<br>♦ Attach the check and Remittance Advice.<br>♦ Skip Section B. Complete Section C. |

**SECTION B:**

| 1. 17-digit TCN | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|

| 2. Pay-to Provider #: | 4. 8-character Iowa Medicaid Recipient ID: (e.g., 1234567A) |
|---|---|

**3. Provider Name and Address:**

**5. Reason for Adjustment or Credit Request:**

| SECTION C: | Provider/Representative Signature: |
|---|---|
| | Date: |

**FISCAL AGENT USE ONLY: REMARKS/STATUS**

**Return All Requests To:**

**ACS**
**PO Box 14422**
**Des Moines, IA 50306-3422**

Iowa Department of Human Services

For Human Services use only:

**General Letter No. 8-AP-98**
Employees' Manual, Title 8
Medicaid Appendix

January 4, 1999

**PHYSICIAN SERVICES MANUAL TRANSMITTAL NO. 99-1**

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***Physician Services Manual***, Table of Contents (page 6), revised; Chapter E, *Coverage and Limitations*, pages 70 through 74, 76 through 78, and 80a, revised.

This revision updates:

- The form numbers for the *Consent Form*, 470-0835 and 470-0835S.
- Policy regarding abortions to reflect changes in the federal law.
- Form 470-0836, *Certification Regarding Abortion*.

**Date Effective**

Upon receipt.

**Material Superseded**

Remove the following pages from ***Physician Services Manual*** and destroy them:

| Page | Date |
|---|---|
| Table of Contents (page 6) | January 1, 1997 |
| **Chapter E** | |
| 70 | January 1, 1997 |
| 71, 72 | March 1, 1993 |
| 73, 74 | 3/94 |
| 76 | January 1, 1997 |
| 77 | October 1, 1993 |
| 78 | March 1, 1993 |
| 80a | March 1, 1995 |

**Additional Information**

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.

Iowa Department of Human Services

For Human Services use only:

**General Letter No. 8-AP-103**
Employees' Manual, Title 8
Medicaid Appendix

March 29, 1999

**PHYSICIAN SERVICES MANUAL TRANSMITTAL NO. 99-2**

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***Physician Services Manual***, Chapter E, *Coverage and Limitations*, pages 7, 115, 116, and 173 through 175, revised.

This revision:

- Reflects changes in the vaccines for children (VFC) schedule.
- Adds the codes for rotavirus and synagis.

**Date Effective**

Upon receipt.

**Material Superseded**

Remove the following pages from ***Physician Services Manual*** and destroy them:

| Page | Date |
|---|---|
| 7 | January 1, 1997 |
| 115, 116 | January 1, 1998 |
| 173-175 | May 1, 1998 |

**Additional Information**

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.

Iowa Department of Human Services

For Human Services use only:

**General Letter No. 8-AP-174**
Employees' Manual, Title 8
Medicaid Appendix

January 9, 2002

**PHYSICIAN SERVICES MANUAL TRANSMITTAL NO. 02-1**

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***Physician Services Manual***, Table of Contents, pages 4, 6, 7, 8, and 9, revised; Chapter E, *Coverage and Limitations*, pages 8, 9, 12 through 18, 64 through 72, 79, 87 through 90, 99 through 102, 119, 120, 159 through 162, 173, 174, and 175, revised; and page 174a, new; Chapter F, *Billing and Payment*, pages 3 and 16, revised; and pages 26 through 29, new.

Chapter E has been revised to:

- Address administrative simplification, as directed by the Health Insurance Portability and Accountability Act of 1996 (HIPPA). Administrative simplification includes use of standard code sets such as CPT codes and elimination of local codes for Medicaid services.

  This release eliminates the W0051 local code for EPSDT "Care for Kids" screens. The preventive office visit codes with modifiers will continue to be used for the service. Both codes will be processed until May 31, 2002.

  This revision also removes codes for injections, except for vaccinations. Please note that all "W" and "Z" codes for injections are no longer valid. They will be processed only until May 31, 2002. Modifiers for vaccination codes are also eliminated.

- Issue a revised from 470-0361, *Report of Examination for a Hearing Aid*.
- Include the revised form 470-2942, *Medicaid Prenatal Risk Assessment*, and remove the requirement for its submission with the *Health Insurance Claim Form*.
- Update the list of surgical procedures requiring preprocedure review.
- Clarify abortion policy.
- Update the directory of maternal health centers
- Reflect changes in the vaccines for children (VFC) schedule and codes for immunization.
- Revise the referral criteria for hematocrit and hemoglobin screening in the EPSDT "Care for Kids" program.
- Update the recommended childhood immunization schedule.

Chapter F is revised to:

- Update form 470-0829, *Request for Prior Authorization*.
- Update billing and payment instructions by providing for an inquiry process for denied claims or if claim payment was not in the amount expected.
- Add two forms:
  - 470-3744, *Provider Inquiry*, and
  - 470-0040, *Credit/Adjustment Request*.

Complete the *Provider Inquiry* if you wish to inquire about a denied claim or if claim payment was not as expected. Complete the *Credit/Adjustment Request* to notify Consultec that:

- A paid claim amount needs to be changed, or
- Funds need to be credited back, or
- An entire *Remittance Advice* should be canceled.

**Date Effective**

Upon receipt.

**Material Superseded**

Remove the following pages from ***Physician Services Manual*** and destroy them:

| Page | Date |
|---|---|
| Table of Contents (page 4) | January 1, 1997 |
| Table of Contents (page 6) | January 1, 1999 |
| Table of Contents (page 7) | January 1, 1997 |
| Table of Contents (page 8) | November 1, 1998 |
| Table of Contents (page 9) | May 1, 1998 |
| **Chapter E** | |
| 8 | February 1, 1995 |
| 9 | August 1, 1995 |
| 12 | January 1, 1997 |
| 13, 14 (MA-2113-0) | 10/96 |
| 15, 16, 16a | May 1, 1993 |
| 17, 18 (470-2942) | 7/97 |
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| 65 | January 1, 1998 |
| 66 | January 1, 1997 |
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| **Chapter F** | |
| 3 (XIX-P-Auth) | 7/97 |
| 16 | May 1, 1998 |

**Additional Information**

The updated provider manual containing the revised pages can be found at:

**www.dhs.state.ia.us/policyanalysis**

If you do not have Internet Access, you may request a paper copy of this Manual Transmittal by sending a written request to:

ACS/Consultec
Manual Transmittal Requests
PO Box 14422
Des Moines, IA 50306-3422

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to Consultec, fiscal agent for the Department of Human Services.

Iowa Department of Human Services

For Human Services use only:

**General Letter No. 8-AP-216**
Employees' Manual, Title 8
Medicaid Appendix

July 28, 2003

**PHYSICIAN SERVICES MANUAL TRANSMITTAL NO. 03-1**

ISSUED BY: Iowa Department of Human Services

SUBJECT: ***PHYSICIAN SERVICES MANUAL***, Table of Contents, pages 4, 7, 8, and 9, revised; Chapter E, *Coverage and Limitations*, pages 5, 8, 9, 10, 17 through 20, 24, 25, 26, 79, 80, 99 through 110, 129, 148 through 154, 157 through 160, and 170 through 184, revised; Chapter F, *Billing and Payment*, pages 7, 8, 9, 13, 19, 20, 26, 27, and 29, revised, and pages 6a and 18a, new.

Chapter E has been revised to:

- Address administrative simplification, as directed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Administrative simplification includes use of standard code sets such as CPT codes and elimination of local codes for Medicaid services. This release eliminates local codes. A crosswalk for the new provider codes is available on the DHS HIPAA website at **www.dhshipaa.iowa.gov/hipaa**. Both codes will be processed until September 30, 2003.
- Revise the content for EPSDT "Care for Kids" screens to reflect current information.

Chapter F has been revised to add instructions for forms 470-3969, *Claim Attachment Control*, and 470-3970, *Prior Authorization Attachment Control*, used to submit paper attachments for an electronic claim or prior authorization request.

Both chapters have been revised to replace references to "Consultec" with "ACS."

**Date Effective**

July 1, 2003

**Material Superseded**

Remove the following pages from ***PHYSICIAN SERVICES MANUAL*** and destroy them:

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| 29 (470-0040) | 4/00 |

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